**UNITED STATES DISTRICT COURT**
**DISTRICT OF PUERTO RICO**

| | |
|---|---|
| In re:<br><br>THE FINANCIAL OVERSIGHT AND MANAGEMENT BOARD FOR PUERTO RICO,<br><br>as representative of<br><br>THE COMMONWEALTH OF PUERTO RICO, *et al.*,<br><br>Debtors.[1] | PROMESA<br>Title III<br><br>No. 17 BK 3283-LTS<br><br>(Jointly Administered) |
| COMMUNITY HEALTH FOUNDATION OF P.R. INC.,<br><br>Movant,<br><br>-against-<br><br>THE FINANCIAL OVERSIGHT AND MANAGEMENT BOARD FOR PUERTO RICO,<br><br>as representative of<br><br>THE COMMONWEALTH OF PUERTO RICO,<br><br>Respondent. | **Re: ECF Nos. 18602** |

**DECLARATION OF FELMARIE CRUZ MORALES IN RESPECT OF OBJECTION OF THE FINANCIAL OVERSIGHT AND MANAGEMENT BOARD FOR PUERTO RICO**

[1] The Debtors in these Title III Cases, along with each Debtor's respective Title III case number and the last four (4) digits of each Debtor's federal tax identification number, as applicable, are the (i) Commonwealth of Puerto Rico (Bankruptcy Case No. 17 BK 3283-LTS) (Last Four Digits of Federal Tax ID: 3481); (ii) Puerto Rico Sales Tax Financing Corporation ("COFINA") (Bankruptcy Case No. 17 BK 3284-LTS) (Last Four Digits of Federal Tax ID: 8474); (iii) Puerto Rico Highways and Transportation Authority ("HTA") (Bankruptcy Case No. 17 BK 3567-LTS) (Last Four Digits of Federal Tax ID: 3808); (iv) Employees Retirement System of the Government of the Commonwealth of Puerto Rico ("ERS") (Bankruptcy Case No. 17 BK 3566-LTS) (Last Four Digits of Federal Tax ID: 9686); (v) Puerto Rico Electric Power Authority ("PREPA") (Bankruptcy Case No. 17 BK 4780-LTS) (Last Four Digits of Federal Tax ID: 3747); and (vi) Puerto Rico Public Building Authority ("PBA") (Bankruptcy Case No. 19-BK-5523-LTS). (Title III case numbers are listed as Bankruptcy Case numbers due to software limitations).

**TO THE MOTION OF COMMUNITY HEALTH FOUNDATION OF P.R. INC. FOR ALLOWANCE AND PAYMENT OF ADMINISTRATIVE EXPENSE**

I, Felmarie Cruz Morales, hereby declare and state as follows:

1. I am Contador III of the Departamento de Salud de Puerto Rico ("PRDOH"), or its English translation, the Department of Health of Puerto Rico. In my role as Contador III, I analyze and approve PRDOH obligations and payment vouchers, analyze service contracts and supplier invoices, and prepare accounts payable reports for the Puerto Rico Department of the Treasury. Particularly with respect to the matters at issue here, I perform certifications for quarterly payments made to federally qualified health centers ("FQHCs") operating in Puerto Rico and calculate the amounts of any wraparound or interim payments due to FQHCs.

2. I am authorized to make and submit this declaration on behalf of PRDOH and I am familiar with certain of the books, records, policies and documents maintained by PRDOH (the "Business Records"). The Business Records are kept by PRDOH in the regular course of its business and are made at or near the time of the events appearing therein by, or from information provided by, persons with knowledge of the activity. It is the regular course of business for PRDOH to make such records. Except as otherwise noted, I have personal knowledge of the matters set forth herein or have relied on information and analyses provided to me by other PRDOH employees and PRDOH's advisors. If called and sworn as a witness, I could and would testify thereto consistent with the facts herein.

3. I make this Declaration in respect of the *Objection of the Financial Oversight and Management Board for Puerto Rico to the Motion of Community Health Foundation of P.R. Inc. for Allowance and Payment of Administrative Expense* (the "Objection").[2] I have read and

[2] Capitalized terms not otherwise defined herein shall have the meanings given to them in the Objection.

understand *Community Health Foundation of P.R. Inc.'s Motion for Allowance and Payment of Administrative Expense* [ECF No. 18602] (the "Motion").

4. Since the filing of the Motion, PRDOH has investigated the amount, if any, that CHF is owed. I have participated in this investigation. In addition, PRDOH has been engaged with the Oversight Board to evaluate the data provided in the Motion, and, in particular, Exhibit 1 thereto.

5. CHF's accounting in the Motion is incorrect in several respects. CHF has used an incorrect formula to determine its PPS rate. CHF's PPS rate calculation is based on a methodology that is not the methodology used in Puerto Rico for Medicaid. Rather, the Commonwealth's State Plan Amendment (as defined below) demonstrates the Commonwealth established an alternative PPS rate for services provided by FQHCs. CHF's incorrect application of the non-Commonwealth PPS rate methodology overstates the amount that CHF is owed by at least nearly ten million dollars.

6. The Motion also does not account for all payments already received by CHF from MCOs, called "fee-for-service" payments.

**Background**

7. The formula for calculating a wraparound payment for Medicaid providers is as follows:

((Medicaid + CHIP visits) x PPS Rate) – Payments Received = Wraparound Payment

8. Through its State Plan Amendment, the Commonwealth received approval from CMS to establish an alternative PPS rate methodology for services provided by FQHCs. Pursuant to this methodology, the PPS rate is determined by dividing an FQHC's total cost of Medicaid-covered services during fiscal years 1999 and 2000 by the total number of Medicaid visits made

during that same period. A true and correct copy of the Puerto Rico State Plan Amendment (the "State Plan Amendment" or "SPA") is attached hereto as **Exhibit A**.

9. Pursuant to the SPA's methodology, it is my understanding the amount of the wraparound payment is calculated based on the difference between the PPS rate and the payment the FQHC received from MCOs for services rendered to federally matchable Medicaid beneficiaries. If revenues received from the MCO are equal to or in excess of what the FQHC would have received under PPS, no wraparound payment is made.

10. Following the approval of the State Plan Amendment, the PRDOH promulgated a manual with respect to reimbursement for FQHCs. A true and correct copy of that certain *Reimbursement Ruling Federally Qualified Health Centers (FQHC) Medicaid Program* (the "Manual"), is attached hereto as **Exhibit B**. It is my understanding the Manual sets forth the same PPS rate methodologies as in the State Plan Amendment for FQHCs existing both before and after January 1, 2001. *See id.* §§ 4.2.1 (existing FQHCs), 4.2.2 (new FQHCs). It also provides instructions on how an FQHC certified after January 1, 2001 must demonstrate its actual cost to establish its base visit rate after two years of applying the interim payment rate. *Id.* Importantly, this includes the requirement that an FQHC "provide evidence of the Medicaid beneficiaries' visits for the same two (2) years." *Id.*

11. It is my understanding PRDOH is obligated to make accurate payments under the Medicaid program to FQHCs, to comply with the SPA, which must be approved by CMS in order for the Commonwealth to access federal Medicaid funds, and to carry out a continuing quality control program to ensure proper operations. I also understand CMS conducts periodic audits of the Commonwealth's operations to determine whether the program is being operated in a cost-efficient manner, funds are being properly expended for the purposes for which they were

appropriated under Federal and State law and regulations, and that the Commonwealth's failure to comply may result in the CMS withholding payments to the Commonwealth for Medicaid services.

12. Should the Commonwealth make payments to CHF beyond what it is truly owed, I believe the Commonwealth could put its own receipt of federal funding for Medicaid services in jeopardy.

13. CHF was designated as an LAL by HRSA in July 2017. A true and correct copy of their designation is attached hereto as **Exhibit C**. It is my understanding CHF requested and received CMS approval to participate as an FQHC in the Medicare program effective August 21, 2017. It was then designated as an FQHC under the Medicaid Act on September 3, 2019. A true and correct copy of the letter of designation, dated October 2, 2019 is attached hereto as **Exhibit D.**

14. It is my understanding CHF has direct and indirect contractual relationships with MCOs operating in the Commonwealth: Triple S Salud, First Medical Health Plan, Inc., and MMM Multi Health, LLC. Through its relationship with Anchor Health Management ("Anchor"), a health services provider operating in the Commonwealth, CHF has indirect contractual relationships with certain MCOs. In other instances, CHF has contracted directly with the MCOs.

15. PRDOH has been unable to verify the amounts asserted in the Motion even with CHF's provision of information in support of the Motion.

16. If CHF were to provide the following, it would assist PRDOH in verifying the assertions in the Motion: certifications of its Medicaid visits for each of the quarters at issue in the Motion – including visit data for any other FQHCs or medical providers with whom it contracts to provide Medicaid services, as well as claims data for all of the revenue it received from MCOs, either directly or indirectly, through Anchor.

**Methodology**

17. The Motion does not use the correct methodology for determining an FQHC's Medicaid PPS rate.

18. For the first two years when CHF was an LAL, it is my understanding the Commonwealth's alternative payment methodology requires using an interim PPS rate based on a neighboring, similarly situated FQHC in the same region. One such FQHC is Centro Health Pro Med (facility: Belaval) ("Belaval"), which had a PPS rate of $146.72 in 2017. For the remaining years CHF was an LAL, under the Commonwealth's alternative payment methodology, its PPS rate is equivalent to the Belaval rate as increased by the MEI. CHF submitted its 2017 and 2018 cost and visit data to the PRDOH in order to calculate its new PPS rate. Following the receipt of these materials, PRDOH calculated CHF's PPS rate for 2019 as $43.69. This was increased to $44.52 by application of the MEI of 1.9% for 2019. A true and correct copy of the PRDOH's PPS calculation, entitled Determinar el PPS Rate Community Health Foundation, is attached hereto as **Exhibit E-1**, and a certified English translation is attached hereto as **Exhibit E-2**.

19. In 2019, CHF received approval to participate in the FQHC program and had its LAL designation removed. Accordingly, under the State Plan Amendment, CHF's PPS rate changed—rather than being calculated based on Belaval's PPS rate, its PPS rate was determined based on its own costs and visits for the prior two years, with annual adjustments pursuant to the MEI.

20. Applying the correct PPS rate formula, as set forth in the Manual and the Commonwealth's State Plan Amendment and approved by CMS, CHF's PPS rate for 2017 through 2021 should be as follows:

| Year | PPS Base Rate | MEI | Correct PPS rate |
|---|---|---|---|
| 2017 | $146.72 | n/a | $146.72 |

| | | | |
|---|---|---|---|
| 2018 | $146.72 | 1.9% | $149.51 |
| Q1 and Q2 2019 | $146.72 | 1.9% | $155.25 |
| Q3 and Q4 2019 | $44.52 | n/a | $44.52 |
| 2020 | $44.52 | 2.2% | $45.50 |
| 2021 | $44.52 | 1.7% | $46.27 |

21. It is my understanding only certain types of Medicaid and CHIP visits may be counted for determining wraparound payments under applicable regulations, excluding, for example, non-FQHC-service-related activities such as mass-immunization programs or community-wide service programs. Accordingly, to properly calculate wraparound payments, in addition to properly calculating the PPS rate, there is a need to ensure that the visit data is appropriately accounted-for. However, PRDOH has not been provided with CHF visit data that is verifiable or complete in connection with the Motion, making that task impossible. Accordingly, PRDOH has been unable to verify CHF's claimed visit totals in Exhibit 1 to the Motion.

22. Over the course of its investigation, the PRDOH determined that CHF has received FFS payments from various MCOs. For example, in the fourth quarter of 2019, CHF received $499,740.31 from First Medical Health Plan, one of the MCOs with which CHF contracts. Exhibit 1 to the Motion, however, does not reflect CHF's receipt of any FFS payments. A true and correct copy of a schedule of FFS payments made to CHF during the period at issue in the Motion that the PRDOH has compiled in connection with its investigation of the Motion is attached hereto as **Exhibit F**. PRDOH's investigation of payments made to CHF is ongoing.

*[Remainder of Page Intentionally Left Blank]*

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct to the best of my information, knowledge, and belief.

Dated: May 25, 2022
San Juan, Puerto Rico

*/s/ Felmarie Cruz Morales*
Felmarie Cruz Morales
Contador III
Puerto Rico Department of Health

# Exhibit A

## Puerto Rico State Plan Amendment

# Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L- [ ]

## Alternative Benefit Plan Populations — ABP1

Identify and define the population that will participate in the Alternative Benefit Plan.

Alternative Benefit Plan Population Name: Adult Group under Section 1902(a)(10)(A)(i)(VIII) of the Act

Identify eligibility groups that are included in the Alternative Benefit Plan's population, and which may contain individuals that meet any targeting criteria used to further define the population.

Eligibility Groups Included in the Alternative Benefit Plan Population:

| | Eligibility Group: | Enrollment is mandatory or voluntary? | |
|---|---|---|---|
| + | Adult Group | Mandatory | X |

Enrollment is available for all individuals in these eligibility group(s). Yes

**Geographic Area**

The Alternative Benefit Plan population will include individuals from the entire state/territory. Yes

Any other information the state/territory wishes to provide about the population (optional)

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20131219

# Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L- [ ]

## Voluntary Benefit Package Selection Assurances - Eligibility Group under Section 1902(a)(10)(A)(i)(VIII) of the Act — ABP2a

| | |
|---|---|
| The state/territory has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements. Therefore the state/territory is deemed to have met the requirements for voluntary choice of benefit package for individuals exempt from mandatory participation in a section 1937 Alternative Benefit Plan. | Yes |

Explain how the state has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements.

Puerto Rico submitted to CMS the Benchmark Plan and identified Triple S Optimo. Puerto Rico then formed formed a workgroup comprised of individuals from ASES and Medicaid to guide the development of the Alternative Benefit Plan. The workgroup provided oversight for the completion of a crosswalk of benefits to the benchmark plan and the current Puerto Rico State Plan and identified service revisions and potential substitution of services. The plans were aligned in most areas however the following benefits were identified for new service or substitution. Throughout the development process, Puerto Rico participated in weekly technical assistance calls led by Central and Regional CMS staff. Throughout these calls sections of the draft ABP were submitted informally and discussed. Each substitution of service and proposed SPA was reviewed by ASES Actuary to ensure alignment of the substitutions of service. Fiscal Impact/PMPM cost estimates were prepared by the actuary for new services. The benefits in the Alternative Benefit Plan are the same as those offered in the Puerto Rico State Plan. In addition the services included meet the requirements of all Essential Health Benefits.



V.20131219

# Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L- [ ]

**Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package** **ABP3**

Select one of the following:

- ○ The state/territory is amending one existing benefit package for the population defined in Section 1.
- ◉ The state/territory is creating a single new benefit package for the population defined in Section 1.

Name of benefit package: Childless Adults Section 1902 A - GHP

**Selection of the Section 1937 Coverage Option**

The state/territory selects as its Section 1937 Coverage option the following type of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package under this Alternative Benefit Plan (check one):

- ◉ Benchmark Benefit Package.
- ○ Benchmark-Equivalent Benefit Package.

The state/territory will provide the following Benchmark Benefit Package (check one that applies):

- ○ The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employee Health Benefit Program (FEHBP).
- ○ State employee coverage that is offered and generally available to state employees (State Employee Coverage):
- ○ A commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state/territory (Commercial HMO):
- ◉ Secretary-Approved Coverage.
  - ◉ The state/territory offers benefits based on the approved state plan.
  - ○ The state/territory offers an array of benefits from the section 1937 coverage option and/or base benchmark plan benefit packages, or the approved state plan, or from a combination of these benefit packages.
    - ◉ The state/territory offers the benefits provided in the approved state plan.
    - ○ Benefits include all those provided in the approved state plan plus additional benefits.
    - ○ Benefits are the same as provided in the approved state plan but in a different amount, duration and/or scope.
    - ○ The state/territory offers only a partial list of benefits provided in the approved state plan.
    - ○ The state/territory offers a partial list of benefits provided in the approved state plan plus additional benefits.

Please briefly identify the benefits, the source of benefits and any limitations:

Benefits in the Alternative Benefit Plan are the same benefits offered in the Puerto Rico State Plan. Due diligence was completed to ensure all Essential Health Benefits are addressed.

**Selection of Base Benchmark Plan**

# Alternative Benefit Plan

The state/territory must select a Base Benchmark Plan as the basis for providing Essential Health Benefits in its Benchmark or Benchmark-Equivalent Package.

The Base Benchmark Plan is the same as the Section 1937 Coverage option. No

Indicate which Benchmark Plan described at 45 CFR 156.100(a) the state/territory will use as its Base Benchmark Plan:

- (•) Largest plan by enrollment of the three largest small group insurance products in the state's small group market.
- ( ) Any of the largest three state employee health benefit plans by enrollment.
- ( ) Any of the largest three national FEHBP plan options open to Federal employees in all geographies by enrollment.
- ( ) Largest insured commercial non-Medicaid HMO.

Plan name: Triple S Optimo

Other Information Related to Selection of the Section 1937 Coverage Option and the Base Benchmark Plan (optional):

Puerto Rico assures that all services in the base benchmark have been accounted for throughout the benefit chart found in ABP 5. Puerto Rico assures the accuracy of information in ABP 5 depicting amount duration and scope parameters of services authorized in the currently approved Medicaid state plan.

## PRA Disclosure Statement



V.20131219

# Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L- ☐

| Alternative Benefit Plan Cost-Sharing | ABP4 |
|---|---|

☑ Any cost sharing described in Attachment 4.18-A applies to the Alternative Benefit Plan.

Attachment 4.18-A may be revised to include cost sharing for ABP services that are not otherwise described in the state plan. Any such cost sharing must comply with Section 1916 of the Social Security Act.

| The Alternative Benefit Plan for individuals with income over 100% FPL includes cost-sharing other than that described in Attachment 4.18-A. | No |
|---|---|

Other Information Related to Cost Sharing Requirements (optional):

## PRA Disclosure Statement

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V.20131219

# Alternative Benefit Plan

OMB Control Number: 0938-1148
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Attachment 3.1-L- [ ]

| Benefits Description | ABP5 |
|---|---|

The state/territory proposes a "Benchmark-Equivalent" benefit package. No

**Benefits Included in Alternative Benefit Plan**

Enter the specific name of the base benchmark plan selected:

Triple S Optimo

Enter the specific name of the section 1937 coverage option selected, if other than Secretary-Approved. Otherwise, enter "Secretary-Approved."

Secretary-Approved

# Alternative Benefit Plan

☑ 1. Essential Health Benefit: Ambulatory patient services Collapse All ☐

Benefit Provided: Physician Services
Source: State Plan 1905(a)
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan

Amount Limit: None
Duration Limit: None

Scope Limit:
Excludes ambulatory setting use of a fetal monitor, cosmetic surgery, procedures to re-establish the ability to procreate, induced abortion experimental procedures, surgeries for sexual transformation, intravenous or inhalation analgesic.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Includes Physicians services whether furnished in the office, the patient's home, a hospital or elsewhere. Excluded practitioners include alternative and sports medicine, iridologists, naturopaths, and cosmetic plastic surgeons. Induced abortion is covered when the pregnancy is a result of rape or incest and/or when the pregnancy puts the mothers life at-risk and in compliance with the Hyde Amendment.

Benefit Provided: Clinic Services
Source: State Plan 1905(a)
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan

Amount Limit: None
Duration Limit: None

Scope Limit:
Excludes services rendered in an outpatient facility that may be performed in a physicians office.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Other Licensed Providers
Source: State Plan 1905(a)

Authorization: None
Provider Qualifications: Medicaid State Plan

Amount Limit: None
Duration Limit: None

# Alternative Benefit Plan

Scope Limit:

Includes all licensed medical professionals required by Puerto Rico local law. | Remove

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Excludes non physician professionals including nurse and physician assistant except those required by local law such as podiatrist, optometrist, clinical psychologists and chiropractors.

Add

# Alternative Benefit Plan

☑ 2. Essential Health Benefit: Emergency services — Collapse All ☐

Benefit Provided: Other Medical Services - Emergency Hospital
Source: State Plan 1905(a) — Remove
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: No limitations
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Other Medical Services-Emergency Transportation
Source: State Plan 1905(a) — Remove
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: Ground, maritime and aerial ambulance services are covered within the territorial limits of Puerto Rico for emergency cases
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

# Alternative Benefit Plan

☑ 3. Essential Health Benefit: Hospitalization — Collapse All ☐

Benefit Provided: Inpatient Hospital Services

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Excludes hospitalization for services which can be rendered in an ambulatory setting, Admission of patients to hospitals for diagnostic purposes only, Expenses for services and/or materials for the comfort of patients only such as television.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Bariatric surgery limited to 1 per lifetime and requires prior authorization.
Transplant services limited to skin, bone and corneal transplants
Due diligence was applied to ensure this service is aligned with the base benchmark coverage.

Add

# Alternative Benefit Plan

☑ 4. Essential Health Benefit: Maternity and newborn care — Collapse All ☐

Benefit Provided: Physician Services - Maternity
Source: State Plan 1905(a) — Remove
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Inpatient Hospital services - Maternity
Source: State Plan 1905(a) — Remove
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: Minimum Stay - 48 hours for vaginal delivery, 96 hours for cesarean delivery
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

# Alternative Benefit Plan

Collapse All ☐

☑ 5. Essential Health Benefit: Mental health and substance use disorder services including behavioral health treatment

Benefit Provided: Behavioral Health Outpatient - Rehab

Source: State Plan Other

Remove

Authorization: None

Provider Qualifications: Other

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Puerto Rico covers individual and group counseling, substance abuse treatment, partial hospitalization, psychiatric care and medication management for enrollees identified as having behavioral health needs without limitation. Provider qualifications are mandated by Puerto Rico law and licensing requirements and include psychologists and psychiatrists.

Benefit Provided: Behavioral Health Inpatient - Rehab

Source: State Plan Other

Remove

Authorization: None

Provider Qualifications: Other

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes mental health and substance abuse services in facilities not designated as IMDs. Puerto Rico covers individual and group counseling, substance abuse treatment, residential treatment services, psychiatric care and medication management for enrollees identified as having behavioral health needs without limitation. Provider qualifications are mandated by Puerto Rico law and licensing requirements and include psychologists and psychiatrists.

Add

# Alternative Benefit Plan

☒ 6. Essential Health Benefit: Prescription drugs

Benefit Provided:

Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

| Prescription Drug Limits (Check all that apply.): | Authorization: | Provider Qualifications: |
|---|---|---|
| ☒ Limit on days supply | Yes | State licensed |
| ☐ Limit on number of prescriptions | | |
| ☐ Limit on brand drugs | | |
| ☐ Other coverage limits | | |
| ☒ Preferred drug list | | |

Coverage that exceeds the minimum requirements or other:

Puerto Rico's ABP prescription Drug Benefit is the same as under the approved Medicaid State Plan for prescribed drugs.

# Alternative Benefit Plan

☒ 7. Essential Health Benefit: Rehabilitative and habilitative services and devices — Collapse All ☐

Benefit Provided: Physical Therapy - Rehabilitation and Habilitation

Source: State Plan 1905(a)(11) — Remove

Authorization: Authorization required in excess of limitation

Provider Qualifications: Medicaid State Plan

Amount Limit: 30 treatments per condition.

Duration Limit: Per year

Scope Limit: Combined limit of 30 sessions applies to habilitation and rehabilitation.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Physical therapy is applied as a habilitative and rehabilitative service as determined medically necessary. Initial 15 sessions available without prior authorization. Additional 15 sessions require prior authorization. The treatment limit is combined with the limit with chiropractic care. An individual may receive a total of 30 physical therapy and/or chiropractic sessions combined. Additional session beyond 30 are allowed with medical necessity and require a prior authorization process.

Benefit Provided: Home Health Services

Source: Other state-defined — Remove

Authorization: Other

Provider Qualifications: Other

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

The approved Puerto Rico State Plan does not cover Home Health services utilizing the Federal Definition. There are no home health agencies in the Commonwealth serving the Medicaid populations. Home Health refers to the location of services. Medicaid provides equipment and medical services to enrollees for at home when medically necessary and as a cost effective alternative to hospitalization. Any state plan service that is medically necessary may be provided in the home if a cost effective alternative to hospitalization Home Health services utilizing the Puerto Rico definition are requested and approved by the MCO and ASES on a case-by-case basis as determined medically necessary. PT services may be provided in the home as medically necessary. When there is a State Plan limit on services, any services provided in-home are counted towards those limitations.

Benefit Provided: Home Health - Prosthetic Devices

Source: State Plan 1905(a)

# Alternative Benefit Plan

Authorization: None

Provider Qualifications: Medicaid State Plan

Remove

Amount Limit: None

Duration Limit: None

Scope Limit: See below

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes prosthetic devices for all of the extremities of the body, ocular therapeutic prosthesis and segmentary system trays for scoliosis surgery and fusion. Other DME limited to equipment necessary for the delivery of oxygen.

Benefit Provided: Chiropractic Care

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: 30 treatments per condition

Duration Limit: per year

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Chiropractic adjustments are provided as a habilitative and rehabilitative service as determined medically necessary. Initial 15 sessions available without prior authorization. Additional 15 sessions require prior authorization. The treatment limit is combined with the limit with physical therapy. An individual may receive a total of 30 physical therapy and/or chiropractic sessions combined. Additional session beyond 30 are allowed with medical necessity and require a prior authorization process.

Benefit Provided: Respiratory Therapy

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

# Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Offered as a habilitative and rehabilitative service as determined medically necessary.

Remove

Benefit Provided: Occupational Therapy

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Offered as a habilitative and rehabilitative service as determined medically necessary

Benefit Provided: Speech Therapy

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Offered as a habilitative and rehabilitative service as determined medically necessary.

Add

# Alternative Benefit Plan

☑ 8. Essential Health Benefit: Laboratory services — Collapse All ☐

Benefit Provided: Diagnostic Lab
Source: State Plan 1905(a)
Remove

Authorization: Other
Provider Qualifications: Medicaid State Plan

Amount Limit: None
Duration Limit: None

Scope Limit: Coverage excludes laboratories for which processing is not available in Puerto Rico.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Prior authorization is not required when provided by a lab within the members Primary Medical Group (PMG). The PMG is a function of the MCO and describes the members selected provider and associated labs and specialist.

Benefit Provided: Other lab and x-ray Services
Source: State Plan 1905(a)
Remove

Authorization: Other
Provider Qualifications: Medicaid State Plan

Amount Limit: None
Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

General Clinical Labs, X-rays, Radiotherapy, Pathology, Pulmonary Function and Electroencephalograms if medically necessary do not require pre-authorization. Prior authorization is not required when provided by a lab within the members Primary Medical Group (PMG)

Add

# Alternative Benefit Plan

☑ 9. Essential Health Benefit: Preventive and wellness services and chronic disease management Collapse All ☐

The state/territory must provide, at a minimum, a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

Benefit Provided:

Source:

Remove

Authorization:

Provider Qualifications:

Amount Limit:

Duration Limit:

Scope Limit:

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

# Alternative Benefit Plan

☑ 10. Essential Health Benefit: Pediatric services including oral and vision care — Collapse All ☐

Benefit Provided:
Medicaid State Plan EPSDT Benefits

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

# Alternative Benefit Plan

☐ 11. Other Covered Benefits from Base Benchmark

Collapse All ☐

# Alternative Benefit Plan

☒ 12. Base Benchmark Benefits Not Covered due to Substitution or Duplication Collapse All ☐

Base Benchmark Benefit that was Substituted: Primary care visit treatments of injury or illness
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under Medicaid state plan as Physician services EHB1. This service covers all ambulatory care providers.
Base Benchmark plan: No limitations

Base Benchmark Benefit that was Substituted: Specialist Visit
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under Medicaid state plan as Physician Services- EHB 1. This service covers all ambulatory care providers.
Base Benchmark: No limitations

Base Benchmark Benefit that was Substituted: Other practitioner office visit
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under Medicaid state plan as Other Licensed Providers in EHB 1
Base Benchmark: Excludes non physician professionals including nurse and physician assistant except those required by local law such as podiatrist, optometrist, clinical psychologists and chiropractors.

Base Benchmark Benefit that was Substituted: Outpatient facility
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under Medicaid state plan as Clinic services EHB 1
Base Benchmark: Excludes services rendered in an outpatient facility that may be performed in a physicians office.

Base Benchmark Benefit that was Substituted: Outpatient Surgery Physician Surgical Services
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under Medicaid state plan as Physician Services EHB 1
Base Benchmark: Excludes cosmetic surgery, procedures to re-establish the ability to procreate, induced abortion, experimental procedures, surgeries for sexual transformation, intravenous or inhalation analgesia.

# Alternative Benefit Plan

Base Benchmark Benefit that was Substituted: Home Health Care Services
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under Medicaid state plan as Home Health Services EHB 7. The approved Puerto Rico State Plan does not cover Home Health services utilizing the Federal Definition. Home Health refers to the location of services. Medicaid provides equipment and medical services to enrollees for at home when medically necessary and as a cost effective alternative to hospitalization.
Base Benchmark: Defines Home Health in the same manner as the Medicaid State plan and limits services to 40 visits only that are initiated within 14 days of a hospitalization of at least 3 days and provided for the same condition as the hospitalization. Combined limit applies to physical, occupational and speech therapy.

Base Benchmark Benefit that was Substituted: Emergency Services
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under Medicaid state plan as Other Medical Services -Emergency Services in EHB 2
Base Benchmark: No limitations.

Base Benchmark Benefit that was Substituted: Emergency Transportation
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under Medicaid state plan as Other Medical Services - Emergency Transportation services EHB 2
Base Benchmark: Covered as reimbursement up to $80.00 per trip

Base Benchmark Benefit that was Substituted: Inpatient Hospital Services
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under Medicaid state plan as Inpatient Hospital Services EHB 3
Base Benchmark: Excludes services for personal comfort such as private rooms and for services or procedures that may be performed in an outpatient setting.

Base Benchmark Benefit that was Substituted: Inpatient physician and surgical services
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under Medicaid state plan as Inpatient Hospital Services EHB 3
Base Benchmark: No limitations

# Alternative Benefit Plan

Base Benchmark Benefit that was Substituted: Skilled Nursing Facility
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Base Benchmark: Limits Skilled Nursing services to 120 days only if initiated within 14 days of a hospitalization of at least 3 days and provided for the same condition as the hospitalization.
The substitution is based on unlimited respiratory therapy, occupational therapy and speech therapy identified in EHB 7 .

Base Benchmark Benefit that was Substituted: Prenatal and Postnatal Care
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under Medicaid state plan as Physician Services EHB 4.
Base Benchmark: No Limitations

Base Benchmark Benefit that was Substituted: Delivery/Inpatient services for Maternity Care
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under Medicaid state plan as Inpatient Hospital Services - Maternity EHB 4
Base Benchmark: Delivery of baby 48 hour minimum for vaginal delivery and 96 hours for cesarean delivery.

Base Benchmark Benefit that was Substituted: Mental/Behavioral Health Outpatient Services
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under Medicaid state plan as Behavioral Health Outpatient EHB 5
Base Benchmark: Limited to 15 units per year for group therapy

Base Benchmark Benefit that was Substituted: Mental/Behavioral Health Inpatient Services
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under Medicaid state plan as Behavioral Health Inpatient services EHB 5
Base Benchmark: Limited to 90 days per year.

Base Benchmark Benefit that was Substituted: Substance Abuse Outpatient Services
Source: Base Benchmark

# Alternative Benefit Plan

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under Medicaid state plan as Behavioral Health Outpatient EHB 5
Base Benchmark: Limited to 15 units per year for each type of service including group therapy, psychiatrist, clinical psychologist and collateral visits.

Remove

Base Benchmark Benefit that was Substituted: Substance Abuse Inpatient Services

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under Medicaid state plan as Behavioral Health Inpatient services EHB 5
Base Benchmark: Limited to 90 days per year.

Base Benchmark Benefit that was Substituted: Outpatient Rehabilitation Services

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under Medicaid state plan as Rehabilitative and Habilitative services EHB 7
Base Benchmark: Limited to 20 physical therapy sessions per year. Does not include occupational, speech therapies, prosthetics and implants orthopedics or cardiac rehabilitation.

Base Benchmark Benefit that was Substituted: Habilitation Services

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under Medicaid state plan as Physical Therapy services EHB 7 and Speech Therapy, Respiratory and Occupational Therapy.
Base Benchmark: Limited to 20 physical therapy sessions per year

Base Benchmark Benefit that was Substituted: Durable Medical Equipment

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Substitution: covered as prosthetic devices in the Medicaid state plan as Home Health - DME services EHB 7
Base Benchmark: Limited to $5,000 per year for rental or purchase of oxygen and necessary equipment for its administration, wheelchair and hospital beds.

Base Benchmark Benefit that was Substituted: Diagnostic Tests

Source: Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under Medicaid state plan as Laboratory Services services EHB 8 and Other Lab and

# Alternative Benefit Plan

X-Ray services EHB 8
Base Benchmark: No limitations

Remove

Base Benchmark Benefit that was Substituted:
Preventive Care/Screening and Immunization

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Duplication: covered under Medicaid state plan as Preventive services EHB 9
Base Benchmark: No limitations

Base Benchmark Benefit that was Substituted:
Routine Eye Exam for Children

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under Medicaid state plan as EPSDT in EHB10
Base Benchmark: Limited to routine exam per year

Base Benchmark Benefit that was Substituted:
Eyeglasses for Children

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under Medicaid state plan as EPSDT in EHB10
Base Benchmark: Limited to 1 per year

Base Benchmark Benefit that was Substituted:
Prescription Drugs

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Benchmark plan is the same as State Plan Coverage in Prescription Drugs EHB 6

Base Benchmark Benefit that was Substituted:
Chiropractic Care

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under Chiropractic Care EHB 7

Base Benchmark Benefit that was Substituted:
Routine Foot Care

Source:
Base Benchmark

# Alternative Benefit Plan

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Physicians Services in EHB 1

Remove

Base Benchmark Benefit that was Substituted:

Transplant Services

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Hospitalization EHB 3

Base Benchmark Benefit that was Substituted:

Barriatric Services

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Hospitalization EHB 3

Base Benchmark Benefit that was Substituted:

Imaging

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under Diagnostic Lab EHB 8

Add

# Alternative Benefit Plan

☐ 13. Other Base Benchmark Benefits Not Covered Collapse All ☐

# Alternative Benefit Plan

☒ 14. Other 1937 Covered Benefits that are not Essential Health Benefits — Collapse All ☐

Other 1937 Benefit Provided: Adult Dental

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: See below

Duration Limit: None

Scope Limit: See below

Other: Limited to (1) comprehensive and periodic exam and films per year. (1) prophylaxis per year. Amalgam and resin restorations, root canal therapy, oral surgery and palliative treatment. General anesthesia only for those with special conditions.

Other 1937 Benefit Provided: Federally Qualified Health centers

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other:

Other 1937 Benefit Provided: Family Planning Services

Source: Section 1937 Coverage Option Benchmark Benefit Package

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

# Alternative Benefit Plan

Other:

Remove

Other 1937 Benefit Provided:
High Risk Pregnancy - Case Management

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Covers only Medicaid eligible women identified as at-risk for pre-term birth or poor pregnancy outcome.

Other:

Other 1937 Benefit Provided:
Extended Services for Pregnant Women

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
All medical and obstetrical services that are medically necessary due to complications of pregnancy including hospitalization beyond minimum stay terms.

Other 1937 Benefit Provided:
Tuberculosis Related Services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

# Alternative Benefit Plan

Scope Limit:

None

Remove

Other:

All medically necessary services related to Tuberculosis care for individuals who receive a diagnosis of Tuberculosis.

Other 1937 Benefit Provided:

Adult vision Exam

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

1 per year

Duration Limit:

None

Scope Limit:

Annual eye exam for adults

Other:

Add

# Alternative Benefit Plan

☐ 15. Additional Covered Benefits (This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.)

Collapse All ☐

## PRA Disclosure Statement

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V.20131219

# Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L- [ ]

**Benefits Assurances** **ABP7**

**EPSDT Assurances**

If the target population includes persons under 21, please complete the following assurances regarding EPSDT. Otherwise, skip to the Prescription Drug Coverage Assurances below.

The alternative benefit plan includes beneficiaries under 21 years of age. Yes

☑ The state/territory assures that the notice to an individual includes a description of the method for ensuring access to EPSDT services (42 CFR 440.345).

☑ The state/territory assures EPSDT services will be provided to individuals under 21 years of age who are covered under the state/territory plan under section 1902(a)(10)(A) of the Act.

Indicate whether EPSDT services will be provided only through an Alternative Benefit Plan or whether the state/territory will provide additional benefits to ensure EPSDT services:

◉ Through an Alternative Benefit Plan.

○ Through an Alternative Benefit Plan with additional benefits to ensure EPSDT services as defined in 1905(r).

Other Information regarding how ESPDT benefits will be provided to participants under 21 years of age (optional):

**Prescription Drug Coverage Assurances**

☑ The state/territory assures that it meets the minimum requirements for prescription drug coverage in section 1937 of the Act and implementing regulations at 42 CFR 440.347. Coverage is at least the greater of one drug in each United States Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

☑ The state/territory assures that procedures are in place to allow a beneficiary to request and gain access to clinically appropriate prescription drugs when not covered.

☑ The state/territory assures that when it pays for outpatient prescription drugs covered under an Alternative Benefit Plan, it meets the requirements of section 1927 of the Act and implementing regulations at 42 CFR 440.345, except for those requirements that are directly contrary to amount, duration and scope of coverage permitted under section 1937 of the Act.

☑ The state/territory assures that when conducting prior authorization of prescription drugs under an Alternative Benefit Plan, it complies with prior authorization program requirements in section 1927(d)(5) of the Act.

**Other Benefit Assurances**

☑ The state/territory assures that substituted benefits are actuarially equivalent to the benefits they replaced from the base benchmark plan, and that the state/territory has actuarial certification for substituted benefits available for CMS inspection if requested by CMS.

☐ The state/territory assures that individuals will have access to services in Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) as defined in subparagraphs (B) and (C) of section 1905(a)(2) of the Social Security Act.

☑ The state/territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Social Security Act.

# Alternative Benefit Plan

- ☑ The state/territory assures that it will comply with the requirement of section 1937(b)(5) of the Act by providing, effective January 1, 2014, to all Alternative Benefit Plan participants at least Essential Health Benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.
- ☑ The state/territory assures that it will comply with the mental health and substance use disorder parity requirements of section 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.
- ☑ The state/territory assures that it will comply with section 1937(b)(7) of the Act by ensuring that benefits provided to Alternative Benefit Plan participants include, for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.
- ☑ The state/territory assures transportation (emergency and non-emergency) for individuals enrolled in an Alternative Benefit Plan in accordance with 42 CFR 431.53.
- ☑ The state/territory assures, in accordance with 45 CFR 156.115(a)(4) and 45 CFR 147.130, that it will provide as Essential Health Benefits a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

## PRA Disclosure Statement

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V.20131219

# Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-L- ☐ OMB Expiration date: 10/31/2014

**Service Delivery Systems** **ABP8**

Provide detail on the type of delivery system(s) the state/territory will use for the Alternative Benefit Plan's benchmark benefit package or benchmark-equivalent benefit package, including any variation by the participants' geographic area.

Type of service delivery system(s) the state/territory will use for this Alternative Benefit Plan(s).

Select one or more service delivery systems:

☒ Managed care.

- ☒ Managed Care Organizations (MCO).
- ☐ Prepaid Inpatient Health Plans (PIHP).
- ☐ Prepaid Ambulatory Health Plans (PAHP).
- ☐ Primary Care Case Management (PCCM).

☐ Fee-for-service.

☐ Other service delivery system.

## Managed Care Options

### Managed Care Assurance

☑ The state/territory certifies that it will comply with all applicable Medicaid laws and regulations, including but not limited to sections 1903(m), 1905(t), and 1932 of the Act and 42 CFR Part 438, in providing managed care services through this Alternative Benefit Plan. This includes the requirement for CMS approval of contracts and rates pursuant to 42 CFR 438.6.

### Managed Care Implementation

Please describe the implementation plan for the Alternative Benefit Plan under managed care including member, stakeholder, and provider outreach efforts.

ASES and Medicaid began work on the development of the ABP in partnership with Triple S (the Benchmark plan provider), Department of Health, Clinical Consultant Dr. Max Miranda, ABARCA Health, and Mercer. In presentations to groups and associations related to the health segment, ASES Director Ricardo Rivera has discussed the ABP and our plan going forward in order to comply with CMS and ACA. Puerto Rico issued public notice on the ASES and Medicaid websites and in circular newspapers. The announcement is attached.

### MCO: Managed Care Organization

The managed care delivery system is the same as an already approved managed care program. Yes

The managed care program is operating under (select one):

- ○ Section 1915(a) voluntary managed care program.
- ○ Section 1915(b) managed care waiver.
- ○ Section 1932(a) mandatory managed care state plan amendment.
- ○ Section 1115 demonstration.
- ○ Section 1937 Alternative (Benchmark) Benefit Plan state plan amendment.

# Alternative Benefit Plan

Identify the date the managed care program was approved by CMS:

Describe program below:

Currently Puerto Rico delivers physical health services through a single contracted PIHP, behavioral health is delivered through a MBHO and pharmacy services are contracted with a pharmacy benefit manager (PBM). Puerto Rico is currently in an open Procurement for full-risk MCOs to deliver fully integrated physical and behavioral health services under one contract by region. The proposal and evaluation process is complete and Puerto Rico is currently engaged in contract negotiations. The MCO contract is in final stages of review by CMS and includes services as described in the ABP. Puerto Rico will continue to utilize the PBM for pharmacy services. The new MCO's and contract will be implemented April 2015.

**Additional Information: MCO (Optional)**

Provide any additional details regarding this service delivery system (optional):

## PRA Disclosure Statement

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V.20131219

# Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-L- [ ]

OMB Expiration date: 10/31/2014

| Employer Sponsored Insurance and Payment of Premiums | ABP9 |
|---|---|
| The state/territory provides the Alternative Benefit Plan through the payment of employer sponsored insurance for participants with such coverage, with additional benefits and services provided through a Benchmark or Benchmark-Equivalent Benefit Package. | No |
| The state/territory otherwise provides for payment of premiums. | No |
| Other Information Regarding Employer Sponsored Insurance or Payment of Premiums: | |

## PRA Disclosure Statement

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V.20131219

# Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L- [ ]

## General Assurances — ABP10

**Economy and Efficiency of Plans**

☑ The state/territory assures that Alternative Benefit Plan coverage is provided in accordance with Federal upper payment limit requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

Economy and efficiency will be achieved using the same approach as used for Medicaid state plan services. Yes

**Compliance with the Law**

☑ The state/territory will continue to comply with all other provisions of the Social Security Act in the administration of the state/territory plan under this title.

☑ The state/territory assures that Alternative Benefit Plan benefits designs shall conform to the non-discrimination requirements at 42 CFR 430.2 and 42 CFR 440.347(e).

☑ The state/territory assures that all providers of Alternative Benefit Plan benefits shall meet the provider qualification requirements of the Base Benchmark Plan and/or the Medicaid state plan.

## PRA Disclosure Statement

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V.20131219

# Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L-

**Payment Methodology** **ABP11**

**Alternative Benefit Plans - Payment Methodologies**

☑ The state/territory provides assurance that, for each benefit provided under an Alternative Benefit Plan that is not provided through managed care, it will use the payment methodology in its approved state plan or hereby submits state plan amendment Attachment 4.19a, 4.19b or 4.19d, as appropriate, describing the payment methodology for the benefit.

**An attachment is submitted.**

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20131219

94

Attachment 4.11-A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

OFFICIAL

State Commonwealth of Puerto Rico

Standards:

The Department of Health is the State Standard-setting body authorized to license all hospitals and related health facilities in Puerto Rico (Act No. 101 of June 1965). To be eligible for a license, institutions must meet the following requirements:

I- Hospitals:

a. Organization of the Medical Staff, with by-laws, rules and regulations.

b. Maintenance of medical record, and its contents, to evaluate quality of care through consultation, special reports, treatment orders, etc. Complete and up-to-date records must be kept for all out and inpatients;

c. Staff Physicians and registered nurses must be on duty or on call at all times. Trained personnel should be responsible for services such as Dietary, Medical Records, Laboratory, Pharmacy, Radiology, etc.

d. Fire safety, sanitation and maintenance of physical plan are stressed;

e. Facilities are evaluated as to adequacy of space and equipment in all services and departments according to services offered to both out and inpatients;

f. All patients admitted must be under the care of a physician duly licensed to practice licensed to practice medicine in Puerto Rico.

II- Nursing Homes:

Nursing home standards are similar to those pertaining to hospitals with the following exceptions:

(1) There is no need for an organized medical staff, and
(2) The number of registered nurses is more limited due to the nature of the services offered.

PR 6/20/74 10/15/74 4/1/74

OFFICIAL

Attachment 4.16-A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Commonwealth of Puerto Rico

The Title XIX Program has cooperative arragements as follows:

1. Department of Social Services for quality control and determination of permanent and total disability.

2. Department of Social Services for Vocational and rehabilitation services.

3. Assistant Secretariat for Maternal and Child Health Services of the Department of Health for early and periodic screening diagnosis and treatment for persons under 21 years of age.

4. Office of Licensure and Certification of Health Facilities of the Department of Health for licensing and Certification of facilities under Title XIX.

PR 6/20/74 10/15/74 4/1/74

# Medicaid Premiums and Cost Sharing

State Name: Puerto Rico

OMB Control Number: 0938-1148

Transmittal Number: PR - 16 - 0002

Expiration date: 10/31/2014

**Cost Sharing Requirements** (1)

1916
1916A
42 CFR 447.50 through 447.57 (excluding 447.55)

The state charges cost sharing (deductibles, co-insurance or co-payments) to individuals covered under Medicaid. Yes

☑ The state assures that it administers cost sharing in accordance with sections 1916 and 1916A of the Social Security Act and 42 CFR 447.50 through 447.57.

**General Provisions**

☑ The cost sharing amounts established by the state for services are always less than the amount the agency pays for the service.

■ No provider may deny services to an eligible individual on account of the individual's inability to pay cost sharing, except as elected by the state in accordance with 42 CFR 447.52(e)(1).

■ The process used by the state to inform providers whether cost sharing for a specific item or service may be imposed on a beneficiary and whether the provider may require the beneficiary to pay the cost sharing charge, as a condition for receiving the item or service, is (check all that apply):

☐ The state includes an indicator in the Medicaid Management Information System (MMIS)

☒ The state includes an indicator in the Eligibility and Enrollment System

☒ The state includes an indicator in the Eligibility Verification System

☒ The state includes an indicator on the Medicaid card, which the beneficiary presents to the provider

☐ Other process

■ Contracts with managed care organizations (MCOs) provide that any cost-sharing charges the MCO imposes on Medicaid enrollees are in accordance with the cost sharing specified in the state plan and the requirements set forth in 42 CFR 447.50 through 447.57.

**Cost Sharing for Non-Emergency Services Provided in a Hospital Emergency Department**

The state imposes cost sharing for non-emergency services provided in a hospital emergency department. Yes

☑ The state ensures that before providing non-emergency services and imposing cost sharing for such services, that the hospitals providing care:

■ Conduct an appropriate medical screening under 42 CFR 489.24, subpart G to determine that the individual does not need emergency services;

■ Inform the individual of the amount of his or her cost sharing obligation for non-emergency services provided in the emergency department;

■ Provide the individual with the name and location of an available and accessible alternative non-emergency services provider;

# Medicaid Premiums and Cost Sharing

- [■] Determine that the alternative provider can provide services to the individual in a timely manner with the imposition of a lesser cost sharing amount or no cost sharing if the individual is otherwise exempt from cost sharing; and
- [■] Provide a referral to coordinate scheduling for treatment by the alternative provider.

[✓] The state assures that it has a process in place to identify hospital emergency department services as non-emergency for purposes of imposing cost sharing. This process does not limit a hospital's obligations for screening and stabilizing treatment of an emergency medical condition under section 1867 of the Act; or modify any obligations under either state or federal standards relating to the application of a prudent-layperson standard for payment or coverage of emergency medical services by any managed care organization.

The process for identifying emergency department services as non-emergency for purposes of imposing cost sharing is:

Non-emergency services are all services or care not considered Emergency Services as determined by the attending physician when an enrollee visits the emergency department. Emergency Services are Physical or Behavioral Health Covered Services furnished by a qualified Provider in an emergency room that are needed to evaluate or stabilize an Emergency Medical Condition or a Psychiatric Emergency that is found to exist using the prudent layperson standard.

Emergency Medical Condition is a medical or Behavioral Health condition, regardless of diagnosis or symptoms, manifesting itself in acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments of bodily functions, serious dysfunction of any bodily organ or part, serious harm to self or other due to an alcohol or drug abuse emergency, serious injury to self or bodily harm to others, or the lack of adequate time for a pregnant women having contractions to safely reach a another hospital before delivery. The Contractor may not impose limits on what constitutes an Emergency Medical Condition.

Psychiatric Emergency is a set of symptoms characterized by an alteration in the perception of reality, feelings, emotions, actions, or behavior, requiring immediate therapeutic intervention in order to avoid immediate damage to the patient, other persons, or property. A Psychiatric Emergency shall not be defined on the basis of lists of diagnoses or symptoms.

No copayment shall be required to provide non-emergency services to an Enrollee who visits a hospital emergency room to receive services if such enrollee, previous to visiting the Hospital Emergency Room, consults the Medical Advice Line and receives a call identification number, and presents such number at the time of the visit to the emergency department.

**Cost Sharing for Drugs**

| | |
|---|---|
| The state charges cost sharing for drugs. | Yes |
| The state has established differential cost sharing for preferred and non-preferred drugs. | Yes |

- [■] The state identifies which drugs are considered to be non-preferred.
- [✓] The state assures that it has a timely process in place to limit cost sharing to the amount imposed for a preferred drug in the case of a non-preferred drug within a therapeutically equivalent or similar class of drugs, if the individual's prescribing provider determines that a preferred drug for treatment of the same condition either will be less effective for the individual, will have adverse effects for the individual, or both. In such cases, reimbursement to the pharmacy is based on the appropriate cost sharing amount.

# Medicaid Premiums and Cost Sharing

**Beneficiary and Public Notice Requirements**

☑ Consistent with 42 CFR 447.57, the state makes available a public schedule describing current cost sharing requirements in a manner that ensures that affected applicants, beneficiaries and providers are likely to have access to the notice. Prior to submitting a SPA which establishes or substantially modifies existing cost sharing amounts or policies, the state provides the public with advance notice of the SPA, specifying the amount of cost sharing and who is subject to the charges, and provides reasonable opportunity for stakeholder comment. Documentation demonstrating that the notice requirements have been met are submitted with the SPA. The state also provides opportunity for additional public notice if cost sharing is substantially modified during the SPA approval process.

**Other Relevant Information**

(1) Medicaid in Puerto Rico is covered by two distinct Commonwealth agencies – The Puerto Rico Medicaid Program (PR Medicaid Program), and The Puerto Rico Health Insurance Administration (ASES). Eligibility determination is handled by the PR Medicaid Program, while ASES contracts with MCOs to provide insurance coverage and enroll beneficiaries.

(2) A public schedule describing current copays is published on the ASES web site at http://www.asespr.gov/, the Puerto Rico Medicaid Program web site at https://www.medicaid.pr.gov/, and on the web sites of MCOs contracted by ASES.

(3) A "Beneficiary Manual" is distributed to all enrollees by MCOs and includes a section which details the co-pay structure.

(4) The Puerto Rico Department of Health (PRDoH), through the Puerto Rico Medicaid Program (Medicaid Program), and the Puerto Rico Health Insurance Administration (PRHIA, Administración de Seguros de Salud de Puerto Rico, or ASES, from its acronym in Spanish) have issued this "Cost Sharing Policy for Medicaid and CHIP Beneficiaries" to establish copayment rules, as required by the Sections 1916 and 1916A of the Social Security Act (SSA) and 42 CFR §§447.50-447.57 (excluding 42 CFR §447.55) of the federal regulation, the State Plan Amendment, and the New Cost Sharing Structure.

## PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20140415

# Medicaid Premiums and Cost Sharing

State Name: Puerto Rico

Transmittal Number: PR - 16 - 0002

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

## Cost Sharing Amounts - Categorically Needy Individuals

1916
1916A
42 CFR 447.52 through 54

The state charges cost sharing to all categorically needy (Mandatory Coverage and Options for Coverage) individuals. Yes

**Services or Items with the Same Cost Sharing Amount for All Incomes**

| | Service or Item | Amount | Dollars or Percentage | Unit | Explanation | |
|---|---|---|---|---|---|---|
| + | | | $ | Visit | | X |

**Services or Items with Cost Sharing Amounts that Vary by Income**

Service or Item: Hospital: Admission

Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

| | Incomes Greater than | Incomes Less than or Equal to | Amount | Dollars or Percentage | Unit | Explanation | |
|---|---|---|---|---|---|---|---|
| + | 0% PRPL | 50% PRPL | 0.00 | $ | Entire Stay | NOTES:<br>1. Co-pay does not apply to any service provided to beneficiary by a provider participating in the Preferred Provider Network (PPN). PPN is subset of providers within General Provider Network. PPN provides services to beneficiaries without cost-sharing or requirement for referrals. Beneficiary is not required to use the PPN. Beneficiary who chooses a non-PPN provider from General Network is subject to co-pays.<br>2. Indicator of co-pay included on ID card that the beneficiary presents to the provider. | X |
| + | 50% PRPL | 100% PRPL | 4.00 | $ | Entire Stay | See Notes 1 and 2 above. | X |
| + | 100% PRPL | 150% PRPL | 5.00 | $ | Entire Stay | See Notes 1 and 2 above. | X |
| + | 150% PRPL | No upper limit | 8.00 | $ | Entire Stay | See Notes 1 and 2 above. | X |
| + | 0% PRPL | 150% PRPL | 0.00 | $ | Entire Stay | Notes:<br>1. Applicable to Medicaid Optional Targeted Low-Income Children, also known as CHIP.<br>2. Indicator of co-pay included on ID card that the beneficiary presents to the provider. | X |

# Medicaid Premiums and Cost Sharing

| | Incomes Greater than | Incomes Less than or Equal to | Amount | Dollars or Percentage | Unit | Explanation | |
|---|---|---|---|---|---|---|---|
| + | 150% PRPL | No Upper Limit | 0.00 | $ | Entire Stay | Notes:<br>1. Applicable to Medicaid Optional Targeted Low-Income Children, also known as CHIP.<br>2. Indicator of co-pay included on ID card that the beneficiary presents to the provider. | X |

Service or Item: Ambulatory visits to Primary Care Physician (PCP), Specialist, or Sub-Specialist

Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

| | Incomes Greater than | Incomes Less than or Equal to | Amount | Dollars or Percentage | Unit | Explanation | |
|---|---|---|---|---|---|---|---|
| + | 0% PRPL | 50% PRPL | 0.00 | $ | Visit | NOTES:<br>1. Co-pay does not apply to any service provided to beneficiary by a provider participating in the Preferred Provider Network (PPN). PPN is subset of providers within General Provider Network. PPN provides services to beneficiaries without cost-sharing or requirement for referrals. Beneficiary is not required to use the PPN. Beneficiary who chooses a non-PPN provider from General Network is subject to co-pays.<br>2. Indicator of co-pay included on ID card that the beneficiary presents to the provider. | X |
| + | 50% PRPL | 100% PRPL | 1.00 | $ | Visit | See Notes 1 and 2 above. | X |
| + | 100% PRPL | 150% PRPL | 1.50 | $ | Visit | See Notes 1 and 2 above. | X |
| + | 150% PRPL | No upper limit | 2.00 | $ | Visit | See Notes 1 and 2 above. | X |
| + | 0% PRPL | 150% PRPL | 0.00 | $ | Visit | Notes:<br>1. Applicable to Medicaid Optional Targeted Low-Income Children, also known as CHIP.<br>2. Indicator of co-pay included on ID card that the beneficiary presents to the provider. | X |
| + | 150% PRPL | No upper limit | 0.00 | $ | Visit | Notes:<br>1. Applicable to Medicaid Optional Targeted Low-Income Children, also known as CHIP.<br>2. Indicator of co-pay included on ID card that the beneficiary presents to the provider. | X |

Service or Item: High-tech Laboratories, Clinical Laboratories, and X-Rays

Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

# Medicaid Premiums and Cost Sharing

| | Incomes Greater than | Incomes Less than or Equal to | Amount | Dollars or Percentage | Unit | Explanation | |
|---|---|---|---|---|---|---|---|
| + | 0% PRPL | 50% PRPL | 0.00 | $ | Procedure | NOTES:<br>1. Co-pay does not apply to any service provided to beneficiary by a provider participating in the Preferred Provider Network (PPN). PPN is subset of providers within General Provider Network. PPN provides services to beneficiaries without cost-sharing or requirement for referrals. Beneficiary is not required to use the PPN. Beneficiary who chooses a non-PPN provider from General Network is subject to co-pays.<br>2. Indicator of co-pay included on ID card that the beneficiary presents to the provider. | X |
| + | 50% PRPL | 100% PRPL | 0.50 | $ | Procedure | See Notes 1 and 2 above. | X |
| + | 100% PRPL | 150% PRPL | 1.00 | $ | Procedure | See Notes 1 and 2 above. | X |
| + | 150% PRPL | No upper limit | 1.50 | $ | Procedure | See Notes 1 and 2 above. | X |
| + | 0% PRPL | 150% PRPL | 0.00 | $ | Procedure | Notes:<br>1. Applicable to Medicaid Optional Targeted Low-Income Children, also known as CHIP.<br>2. Indicator of co-pay included on ID card that the beneficiary presents to the provider. | X |
| + | 150% PRPL | No upper limit | 0.00 | $ | Procedure | Notes:<br>1. Applicable to Medicaid Optional Targeted Low-Income Children, also known as CHIP.<br>2. Indicator of co-pay included on ID card that the beneficiary presents to the provider. | X |

Service or Item: Special Diagnostic Tests

Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

| | Incomes Greater than | Incomes Less than or Equal to | Amount | Dollars or Percentage | Unit | Explanation | |
|---|---|---|---|---|---|---|---|
| + | 0% PRPL | 50% PRPL | 0.00 | $ | Procedure | NOTES:<br>1. Co-pay does not apply to any service provided to beneficiary by a provider participating in the Preferred Provider Network (PPN). PPN is subset of providers within General Provider Network. PPN provides services to beneficiaries without cost-sharing or requirement for referrals. Beneficiary is not required to use the PPN. Beneficiary who chooses a non-PPN provider from General Network is subject to co-pays.<br>2. Indicator of co-pay included on ID card that the beneficiary presents to the provider. | X |
| + | 50% PRPL | 100% PRPL | 1.00 | $ | Procedure | See Notes 1 and 2 above. | X |
| + | 100% PRPL | 150% PRPL | 1.50 | $ | Procedure | See Notes 1 and 2 above. | X |

# Medicaid Premiums and Cost Sharing

| | Incomes Greater than | Incomes Less than or Equal to | Amount | Dollars or Percentage | Unit | Explanation | |
|---|---|---|---|---|---|---|---|
| + | 150% PRPL | No upper limit | 2.00 | $ | Procedure | See Notes 1 and 2 above. | X |
| + | 0% PRPL | 150% PRPL | 0.00 | $ | Procedure | Notes:<br>1. Applicable to Medicaid Optional Targeted Low-Income Children, also known as CHIP.<br>2. Indicator of co-pay included on ID card that the beneficiary presents to the provider. | X |
| + | 150% PRPL | No upper limit | 0.00 | $ | Procedure | Notes:<br>1. Applicable to Medicaid Optional Targeted Low-Income Children, also known as CHIP.<br>2. Indicator of co-pay included on ID card that the beneficiary presents to the provider. | X |

Service or Item: Dental: Preventive and/or Restorative

Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

| | Incomes Greater than | Incomes Less than or Equal to | Amount | Dollars or Percentage | Unit | Explanation | |
|---|---|---|---|---|---|---|---|
| + | 0% PRPL | 50% PRPL | 0.00 | $ | Procedure | Notes:<br>1. Indicator of co-pay included on ID card that the beneficiary presents to the provider.<br>2. Dental providers are not part of the Preferred Provider Network (PPN). | X |
| + | 50% PRPL | 100% PRPL | 1.00 | $ | Procedure | See Notes 1 and 2 above. | X |
| + | 100% PRPL | 150% PRPL | 1.50 | $ | Procedure | See Notes 1 and 2 above. | X |
| + | 150% PRPL | No upper limit | 2.00 | $ | Procedure | See Notes 1 and 2 above. | X |
| + | 0% PRPL | 150% PRPL | 0.00 | $ | Procedure | Notes:<br>1. Applicable to Medicaid Optional Targeted Low-Income Children, also known as CHIP.<br>2. Indicator of co-pay included on ID card that the beneficiary presents to the provider. | X |
| + | 150% PRPL | No upper limit | 0.00 | $ | Procedure | Notes:<br>1. Applicable to Medicaid Optional Targeted Low-Income Children, also known as CHIP.<br>2. Indicator of co-pay included on ID card that the beneficiary presents to the provider. | X |

Service or Item: Pharmacy: Preferred

Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

# Medicaid Premiums and Cost Sharing

| | Incomes Greater than | Incomes Less than or Equal to | Amount | Dollars or Percentage | Unit | Explanation | |
|---|---|---|---|---|---|---|---|
| + | 0% PRPL | 50% PRPL | 0.00 | $ | Other | Notes:<br>1. Indicator of co-pay included on ID card that the beneficiary presents to the provider.<br>2. Co-pay charged for each covered drug dispensed.<br>3. Pharmacies are not part of the Preferred Provider Network (PPN). | X |
| + | 50% PRPL | 100% PRPL | 1.00 | $ | Other | See Notes 1, 2, and 3 above. | X |
| + | 100% PRPL | 150% PRPL | 2.00 | $ | Other | See Notes 1, 2, and 3 above. | X |
| + | 150% PRPL | No upper limit | 3.00 | $ | Other | See Notes 1, 2, and 3 above. | X |
| + | 0% PRPL | 150% PRPL | 0.00 | $ | Other | Notes:<br>1. Applicable to Medicaid Optional Targeted Low-Income Children, also known as CHIP.<br>2. Indicator of co-pay included on ID card that the beneficiary presents to the provider. | X |
| + | 150% PRPL | No upper limit | 0.00 | $ | Item | Notes:<br>1. Applicable to Medicaid Optional Targeted Low-Income Children, also known as CHIP.<br>2. Indicator of co-pay included on ID card that the beneficiary presents to the provider. | X |

Service or Item: Pharmacy: Non-Preferred

Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

| | Incomes Greater than | Incomes Less than or Equal to | Amount | Dollars or Percentage | Unit | Explanation | |
|---|---|---|---|---|---|---|---|
| + | 0% PRPL | 50% PRPL | 0.00 | $ [redacted] | Other | Notes:<br>1. Indicator of co-pay included on ID card that the beneficiary presents to the provider.<br>2. Co-pay charged for each covered drug dispensed.<br>3. Pharmacies are not part of the Preferred Provider Network (PPN). | X |
| + | 50% PRPL | 100% PRPL | 3.00 | $ | Other | See Notes 1, 2, and 3 above. | X |
| + | 100% PRPL | 150% PRPL | 4.00 | $ | Other | See Notes 1, 2, and 3 above. | X |
| + | 150% PRPL | No upper limit | 6.00 | $ | Other | See Notes 1, 2, and 3 above. | X |
| + | 0% PRPL | 150% PRPL | 0.00 | $ | Other | Notes:<br>1. Applicable to Medicaid Optional Targeted Low-Income Children, also known as CHIP.<br>2. Indicator of co-pay included on ID card that the beneficiary presents to the provider. | X |
| + | 150% PRPL | No upper limit | 0.00 | $ | Other | Notes:<br>1. Applicable to Medicaid Optional Targeted Low-Income Children, also known as CHIP.<br>2. Indicator of co-pay included on ID card that the beneficiary presents to the provider. | X |

# Medicaid Premiums and Cost Sharing

Service or Item: Non-Emergency Services Provided in a Hospital Emergency Room (ER) — Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

| | Incomes Greater than | Incomes Less than or Equal to | Amount | Dollars or Percentage | Unit | Explanation | |
|---|---|---|---|---|---|---|---|
| + | 0% PRPL | 50% PRPL | 0.00 | $ | Visit | NOTES:<br>1. Co-pay does not apply to any service provided to beneficiary by a provider participating in the Preferred Provider Network (PPN). PPN is subset of providers within General Provider Network. PPN provides services to beneficiaries without cost-sharing or requirement for referrals. Beneficiary is not required to use the PPN. Beneficiary who chooses a non-PPN provider from General Network is subject to co-pays.<br>2. Co-pay for non-emergency visit to hospital emergency room may be waived by calling the Medical Advice Line and receiving a code to waive the co-pay.<br>3. Indicator of co-pay included on ID card that the beneficiary presents to the provider. | X |
| + | 50% PRPL | 100% PRPL | 4.00 | $ | Visit | See Notes 1, 2, and 3 above. | X |
| + | 100% PRPL | 150% PRPL | 5.00 | $ | Visit | See Notes 1, 2, and 3 above. | X |
| + | 150% PRPL | No upper limit | 8.00 | $ | Visit | See Notes 1, 2, and 3 above. | X |
| + | 0% PRPL | 150% PRPL | 0.00 | $ | Visit | Notes:<br>1. Applicable to Medicaid Optional Targeted Low-Income Children, also known as CHIP.<br>2. Indicator of co-pay included on ID card that the beneficiary presents to the provider. | X |
| + | 150% PRPL | No upper limit | 0.00 | $ | Visit | Notes:<br>1. Applicable to Medicaid Optional Targeted Low-Income Children, also known as CHIP.<br>2. Indicator of co-pay included on ID card that the beneficiary presents to the provider. | X |

Service or Item: Non-Emergency Services Provided in a non-Hospital / Freestanding Emergency Room — Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

# Medicaid Premiums and Cost Sharing

| | Incomes Greater than | Incomes Less than or Equal to | Amount | Dollars or Percentage | Unit | Explanation | |
|---|---|---|---|---|---|---|---|
| + | 0% PRPL | 50% PRPL | 0.00 | $ | Visit | NOTES:<br>1. Co-pay does not apply to any service provided to beneficiary by a provider participating in the Preferred Provider Network (PPN). PPN is subset of providers within General Provider Network. PPN provides services to beneficiaries without cost-sharing or requirement for referrals. Beneficiary is not required to use the PPN. Beneficiary who chooses a non-PPN provider from General Network is subject to co-pays.<br>2. Indicator of co-pay included on ID card that the beneficiary presents to the provider. | X |
| + | 50% PRPL | 100% PRPL | 2.00 | $ | Visit | See Notes 1 and 2 above. | X |
| + | 100% PRPL | 150% PRPL | 3.00 | $ | Visit | See Notes 1 and 2 above. | X |
| + | 150% PRPL | No upper limit | 4.00 | $ | Visit | See Notes 1 and 2 above. | X |
| + | 0% PRPL | 150% PRPL | 0.00 | $ | Visit | Notes:<br>1. Applicable to Medicaid Optional Targeted Low-Income Children, also known as CHIP.<br>2. Indicator of co-pay included on ID card that the beneficiary presents to the provider. | X |
| + | 150% PRPL | No upper limit | 0.00 | $ | Visit | Notes:<br>1. Applicable to Medicaid Optional Targeted Low-Income Children, also known as CHIP.<br>2. Indicator of co-pay included on ID card that the beneficiary presents to the provider. | X |

Add Service or Item

**Cost Sharing for Non-preferred Drugs Charged to Otherwise Exempt Individuals**

If the state charges cost sharing for non-preferred drugs (entered above), answer the following question:

The state charges cost sharing for non-preferred drugs to otherwise exempt individuals. No

**Cost Sharing for Non-emergency Services Provided in the Hospital Emergency Department Charged to Otherwise Exempt Individuals**

If the state charges cost sharing for non-emergency services provided in the hospital emergency department (entered above), answer the following question:

The state charges cost sharing for non-emergency services provided in the hospital emergency department to otherwise exempt individuals. No

# Medicaid Premiums and Cost Sharing

## PRA Disclosure Statement

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V.20140415

# Medicaid Premiums and Cost Sharing

State Name: Puerto Rico

OMB Control Number: 0938-1148

Transmittal Number: PR - 16 - 0002

Expiration date: 10/31/2014

| Cost Sharing Amounts - Medically Needy Individuals | CAN |
|---|---|
| 1916<br>1916A<br>42 CFR 447.52 through 54 | |
| The state charges cost sharing to all medically needy individuals. | Yes |
| The cost sharing charged to medically needy individuals is the same as that charged to categorically needy individuals. | Yes |

## PRA Disclosure Statement

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V.20140415

# Medicaid Premiums and Cost Sharing

State Name: Puerto Rico

OMB Control Number: 0938-1148

Transmittal Number: PR - 16 - 0002

Expiration date: 10/31/2014

| Cost Sharing Amounts - Targeting | |
|---|---|
| 1916<br>1916A<br>42 CFR 447.52 through 54 | |
| The state targets cost sharing to a specific group or groups of individuals. | No |

## PRA Disclosure Statement

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V.20140415

# Medicaid Premiums and Cost Sharing

State Name: Puerto Rico

OMB Control Number: 0938-1148

Transmittal Number: PR - 16 - 0002

Expiration date: 10/31/2014

**Cost Sharing Conditions**

42 CFR 447.56
1916
1916A

☑ The state administers cost sharing in accordance with the limitations described at 42 CFR 447.56, and 1916(a)(2) and (j) and 1916A(b) of the Social Security Act, as follows:

**Exemptions**

**Groups of Individuals - Mandatory Exemptions**

The state may not impose cost sharing upon the following groups of individuals:

- ■ Individuals ages 1 and older, and under age 18 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118).
- ■ Infants under age 1 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118), whose income does not exceed the higher of:
  - ■ 133% FPL; and
  - ■ If applicable, the percent FPL described in section 1902(l)(2)(A)(iv) of the Act, up to 185 percent.
- ■ Disabled or blind individuals under age 18 eligible for the following eligibility groups:
  - ■ SSI Beneficiaries (42 CFR 435.120).
  - ■ Blind and Disabled Individuals in 209(b) States (42 CFR 435.121).
  - ■ Individuals Receiving Mandatory State Supplements (42 CFR 435.130).
- ■ Children for whom child welfare services are made available under Part B of title IV of the Act on the basis of being a child in foster care and individuals receiving benefits under Part E of that title, without regard to age.
- ■ Disabled children eligible for Medicaid under the Family Opportunity Act (1902(a)(10)(A)(ii)(XIX) and 1902(cc) of the Act).
- ■ Pregnant women, during pregnancy and through the postpartum period which begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends, except for cost sharing for services specified in the state plan as not pregnancy-related.
- ■ Any individual whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs.
- ■ An individual receiving hospice care, as defined in section 1905(o) of the Act.
- ■ Indians who are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services.
- ■ Individuals who are receiving Medicaid because of the state's election to extend coverage to the Certain Individuals Needing Treatment for Breast or Cervical Cancer eligibility group (42 CFR 435.213).

# Medicaid Premiums and Cost Sharing

**Groups of Individuals - Optional Exemptions**

The state may elect to exempt the following groups of individuals from cost sharing:

The state elects to exempt individuals under age 19, 20 or 21, or any reasonable category of individuals 18 years of age or over. **Yes**

Indicate below the age of the exemption:

- ○ Under age 19
- ○ Under age 20
- ◉ Under age 21
- ○ Other reasonable category

The state elects to exempt individuals whose medical assistance for services furnished in a home and community-based setting is reduced by amounts reflecting available income other than required for personal needs. **No**

**Services - Mandatory Exemptions**

The state may not impose cost sharing for the following services:

- ☑ Emergency services as defined at section 1932(b)(2) of the Act and 42 CFR 438.114(a).
- ☑ Family planning services and supplies described in section 1905(a)(4)(C) of the Act, including contraceptives and pharmaceuticals for which the state claims or could claim federal match at the enhanced rate under section 1903(a)(5) of the Act for family planning services and supplies.
- ☑ Preventive services, at a minimum the services specified at 42 CFR 457.520, provided to children under 18 years of age regardless of family income, which reflect the well-baby and well child care and immunizations in the Bright Futures guidelines issued by the American Academy of Pediatrics.
- ☑ Pregnancy-related services, including those defined at 42 CFR 440.210(a)(2) and 440.250(p), and counseling and drugs for cessation of tobacco use. All services provided to pregnant women will be considered pregnancy-related, except those services specificially identified in the state plan as not being related to pregnancy.
- ☑ Provider-preventable services as defined in 42 CFR 447.26(b).

**Enforceability of Exemptions**

The procedures for implementing and enforcing the exemptions from cost sharing contained in 42 CFR 447.56 are (check all that apply):

- ☑ To identify that American Indians/Alaskan Natives (AI/AN) are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services in accordance with 42 CFR 447.56(a)(1)(x), the state uses the following procedures:
  - ☐ The state accepts self-attestation
  - ☐ The state runs periodic claims reviews
  - ☒ The state obtains an Active or Previous User Letter or other Indian Health Services (IHS) document
  - ☐ The Eligibility and Enrollment and MMIS systems flag exempt recipients

# Medicaid Premiums and Cost Sharing

☐ Other procedure

Additional description of procedures used is provided below (optional):

Compliance with AI/AN cost sharing exemption will be monitored by ASES.

■ To identify all other individuals exempt from cost sharing, the state uses the following procedures (check all that apply):

☐ The MMIS system flags recipients who are exempt

☐ The Eligibility and Enrollment System flags recipients who are exempt

☐ The Medicaid card indicates if beneficiary is exempt

☐ The Eligibility Verification System notifies providers when a beneficiary is exempt

☒ Other procedure

Description:

(1) Contracts between ASES and MCOs include the requirement to exempt populations and services defined in 42 CFR 447.56(a). MCOs are required by contract to make these exemptions know to beneficiaries and providers.

(2) Compliance with cost sharing exemptions will be monitored by ASES.

(3) ASES requires that the MCOs, MAOs, and PBMs inform providers whether the copayment for a specific service may be imposed on a beneficiary and whether the provider may require the beneficiary to pay the copayment, as a condition for receiving the service, through an indicator:
1. In the Eligibility and Enrollment System;
2. In the Eligibility Verification System; and
3. On the Beneficiary Identification Card.
4. Contracts between ASES and MCOs (MAOs for Platino Plans) and providers shall include the Cost Sharing Policy. MCOs and MAOs will monitor the providers' compliance with the Cost Sharing Policy's requirement.

Additional description of procedures used is provided below (optional):

**Payments to Providers**

☑ The state reduces the payment it makes to a provider by the amount of a beneficiary's cost sharing obligation, regardless of whether the provider has collected the payment or waived the cost sharing, except as provided under 42 CFR 447.56(c).

**Payments to Managed Care Organizations**

The state contracts with one or more managed care organizations to deliver services under Medicaid. Yes

☑ The state calculates its payments to managed care organizations to include cost sharing established under the state plan for beneficiaries not exempt from cost sharing, regardless of whether the organization imposes the cost sharing on its recipient members or the cost sharing is collected.

# Medicaid Premiums and Cost Sharing

**Aggregate Limits**

☑ Medicaid premiums and cost sharing incurred by all individuals in the Medicaid household do not exceed an aggregate limit of 5 percent of the family's income applied on a quarterly or monthly basis.

■ The percentage of family income used for the aggregate limit is:

- ◉ 5%
- ○ 4%
- ○ 3%
- ○ 2%
- ○ 1%
- ○ Other: [ ] %

■ The state calculates family income for the purpose of the aggregate limit on the following basis:

- ◉ Quarterly
- ○ Monthly

The state has a process to track each family's incurred premiums and cost sharing through a mechanism that does not rely on beneficiary documentation. **No**

Explain why the state's premium and cost sharing rules do not place beneficiaries at risk of reaching the aggregate family limit:

Since July 1, 2016, Puerto Rico has implemented a cost-sharing structure that does not place beneficiaries at risk of reaching the aggregate limit.

The state has a documented appeals process for families that believe they have incurred premiums or cost sharing over the aggregate limit for the current monthly or quarterly cap period. **Yes**

Describe the appeals process used:

The Puerto Rico Medicaid Program assures that the New Cost Sharing Structure does not place beneficiaries at risk of reaching the aggregate limit. Nevertheless, the Program has a documented reimbursement request process for individuals that believe they have incurred cost sharing over the aggregate limit for the quarterly cap period, which includes an explanation of his/her right to appeal any decision and request a fair hearing. The written communication to the beneficiary under the process includes an explanation of his/her right to appeal any decision and request a fair hearing.

■ Describe the process used to reimburse beneficiaries and/or providers if the family is identified as paying over the aggregate limit for the month/quarter:

Puerto Rico has a Process to Request Reimbursement of Excess Cost-Sharing Payments, which allows a beneficiary to request a reimbursement when he/she understands that his/her aggregate limit for cost-sharing has been exceeded in a quarter. Reimbursement requests will be investigated to validate the beneficiary's eligibility and aggregate limit for the quarter. For validated requests, all service claims for the beneficiary's family in the quarter will be examined and the aggregate, incurred cost-sharing amount calculated and then compared to the aggregate cost-sharing limit for the beneficiary. For cases in which an excess cost-sharing amount has been incurred, a reimbursement amount will be calculated. In all cases, a written response will be sent to the beneficiary with an explanation of the results of the

investigation. Where a reimbursement is due, the written response will be accompanied by a payment to the beneficiary of the excess amount.

☒ Describe the process for beneficiaries to request a reassessment of their family aggregate limit if they have a change in circumstances or if they are being terminated for failure to pay a premium:

Any beneficiary who notifies the Medicaid Program of a change in circumstances will be re-evaluated and the family aggregate limit will be re-calculated as an inherent part of the re-evaluation process.

The state imposes additional aggregate limits, consistent with 42 CFR 447.56(f)(5). No

## PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20140415

STATE: COMMONWEALTH OF PUERTO RICO

OFFICIAL

Methods and Standards for Establishing Payments of Reasonable Costs of Inpatient Hospital Services.

General Statements:

Inpatient hospitalservices are limited to those rendered in public facilities including contract facilities.

Medicaid will not pay for services with inappropriate level of care.

Claims are processed by State Agency.

Prospective Rate Determination:

An all inclusive simple prospective per-diem reimbursement rate for inpatient hospital services will be established. The system still use the Medicare audited cost reports as the base for Medicaid rates.

Base Year:

The base year for 1985 and subsequent year Medicaid rates will be the individual hospitals Medicare TEFRA base year.

Inflation Factor:

PRDOH, using TEFRA base year rates as base period will increase such rates by 100% of the published TEFRA increase as an inflation factor. Compatibility with Puerto Rico health care costs was the determining factor in reaching the decision to use the TEFRA increase.

Allowable Costs:

The Medicare definition of allowable cost, plus other Medicaid costs such as Professional Services including Group Practice Contracts, Intern and Residents and Nursery costs shall be used to establish Medicaid Inpatient Costs.

NOV 7 1991

TN 91-2 Approval Date

Supersedes TN 84-4 Effective Date JUL 1 1991

Attachment 4.19 A Page 2

OFFICIAL

Rates Appeals Procedure;

Due to unique characteristic of our Medicaid Program where all participating providers are public facilities or contracted hospitals, the rates appeals procedure is not a significant part of our methods and standards for setting rates. Nevertheless, any provider of inpatient services may request a review of their rate in the event that the provider encounters extraordinary circumstances or a change in the case mix as described in federal regulations placing a ceiling in the rate of hospital cost increases.

Upper Limits:

The necessary mechanism for insuring that the lower of costs or changes will be paid according to 42 CFR 447-271 and Medicare cost limits will be applied as per 42CFR 405.463.

Hospitals which serve disproportionate number of low income patients:

All participating hospitals, public and contract operated, serve a large number of low income patients, and none disproportionately so.

PR has no DSH program, by statute

Determination of Patient Days:

Patient Days-unit which stands for services rendered to an inpatient for a 24 hour internal. The standard to be used in calculating this unit are as follows:

a. The 24 hour interval between the census-taking hour on two consecutive days.

b. Admission day count as a patient day, but not so the discharge day or the day of death.

c. Total patient day for a specific day will be that day census plus one additional day for each patient that is admitted and discharged or deceased on the same day.

d. A patient day must never be divided or reported as a fraction day.

e. In Puerto Rico, three newborn patient days equal to one adult patient day.

Assurance for change of Ownership (DEFRA 2314)

In Puerto Rico, only Government owned or contracted hospitals are paid to provide services to Medicaid eligibles. Consequently, a change of ownership would become a private hospital which would not receive any

OFFICIAL

payment for Medicaid Eligibles. In the case of contracted hospitals, while a transfer of plant and equipment takes place, the transfer is valid only for the duration of the contract and does not involve reevaluation of assets.

Therefore, it is hereby assured that payments to hospitals in Puerto Rico under the Medicaid Program will not be increased solely as a result of change of ownership.

Citation

42 CFR 447, 434, 438, AND 1902 (a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Health Care Acquired Conditions

The State identifies the following Health Care-Acquired Conditions for non-payments under Section 4.19 A of this State Plan.

X Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement surgery or hip replacement surgery in pediatric and obstetric patients.

Other Provider Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section(s) 4.19 A of this state Plan.

X Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

___ Additional Other Provider-Preventable Conditions identified below

Effective May 2, 2013, reimbursement for inpatient hospital services shall be based on the Provider Preventable Conditions (PPC) policy defined in 42 CFR 447.26.

Provider Preventable Conditions are defined as two distinct categories: Health Care Acquired Conditions (HCAC) and Other Provider Preventable Conditions (OPPC).

In Puerto Rico, managed care entities and third party administrators' contract with provider and pay provider; there is no fee for service program. The managed care entities and third party administrators shall exclude payment for diagnoses not present on admission for any HCAC. The managed care entities are third party administrators shall report to Puerto Rico on the occurrence of HCACs, OPPCs and the corresponding reductions in payment on a [monthly] basis.

No payment shall be made for inpatient services for OPPCs. OPPCs include the three Medicare National Coverage Determinations: wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure on the wrong patient.

No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by the provider.

Reductions in provider payment may be limited to the extent that the following apply:

i. The identified PPC(s) would otherwise result in an increase in payment.
ii. The Territory can reasonably isolate for non-payment the portion of the payment directly related to treatment for, and related to, PPC(s)

Non-payment of PPCs shall not prevent access to services for Medicaid beneficiaries.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE Commonwealth of Puerto Rico

Methods and Standards for Establishing Payment Rates for each of the other Types of Care or Services

1a. Outpatient hospital services: Reasonable cost as specified in federal Reg. 250.30 (B) (3) (ii). There is an all-inclusive rate for services provided in governmental medical installations including contract facilities.

1b. Rural Health Clinics:

"Provider clinics" will be reimbursed on the basis of the principles specified in the Medicare regulations located at 42-CFR-405 Part D.

"Non-provider clinics" will be paid for each ambulatory service, other than rural health clinic services, at rates or charges established by the State, subject to the upper limits specific in 42-CFR-447.321. Rural health clinic services will be paid at the Medicare reimbursement rate per visit, as specified in 42-CFR-405-2426, - 405-2429.

c. Federally Qualified Health Care Centers
These will be reimbursed based upon the principles specified in the Medicare regulations at 42 CFR 405.

2. Other laboratory and X-ray services-

Reimbursement on basis of an all-inclusive out-patient hospital or clinic rates.

3. Skilled nursing home services-

Limited to services provided in public facilities.
No FFP presently claimed for these services.

4. Physicians' Services

a) Physicians and other practitioners on salary in clinics and other organized systems-Actual cost included in the clinic fee.

b) Private practitioners: will be paid according to a standard fee regulated by the Secretary of Health.

5. Dental Services-

Limited to services provided in public facilities including contract facilities. Reimbursement as part of an all inclusive out-patient hospital or clinic rate.

6. Prescribed drugs and medical supplies-

TN 90-2 SEP 07 1990

Supersedes TN 84-3 APR 01 1990

Reimbursement on basis of an all inclusive out-patient hospital or clinic rate.

7. Clinic Services

Reasonable cost as specified in Federal Reg. 250.30 (B) (3) (ii). There is an all inclusive rate for services provided in governmental medical installations including contract facilities.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: COMMONWEALTH OF PUERTO RICO

Payment Rates for Obstetrical and Pediatric Services are in accord with Section 6402 of the Omnibus Budget Reconciliation Act of 1989. (P.L. 101-239)

All Medicaid services are furnished through public facilities, and all public facilities furnish services. There are no true fee-for service payment rates. However, obstetrical and pediatric services (furnished through the public system) are available to Medicaid recipients to the same extent that they are available to the general population.

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STATE PLAN UNDER THE SOCIAL SECURITY ACT
STATE Commonwealth of Puerto Rico

**Methodology to Establish a Prospective Payment System (PPS) for Federally Qualified Health Centers and Rural Health Centers in accordance with the Benefits Improvement and Protection Act of 2000 (BIPA)**

The Medicaid State Agency will determine the total costs of the Medicaid covered services furnished by the FQHCs/RHCs during fiscal years 1999 and 2000 and divide these costs by the total number of visits made to the FQHC/RHC by Federally matchable Medicaid beneficiaries. The resulting quotient will be the FQHC/RHC prospective payment rate (PPS) for 2001. This PPS rate will be updated annually in accordance with the Medicare Economic index (MEI) as published by the Centers for Medicare and Medicaid Services. PPS rates will also be adjusted for a change in the scope of services. A change in the scope of services is defined as a change in the type, intensity, duration and/or amount of services.

For new providers (entities first qualifying as FQHC/RHC after December 31,2000), interim PPS rates will be calculated. These rates will be subject to final settlements through December 31 of the initial and second year of the FQHC/RHC's existence. New FQHC/RHC's rate years will be calendar years, thus the initial year may represent less than a full year of operation. The interim PPS encounter rate will be the Commonwealthwide average PPS encounter rate. After the first two years; the PPS encounter rate will be based on the average of the first two years' encounter rates, as determined at final settlement, adjusted by the MEI and any changes in scope of services.

TN 02-01 Approved date APR 08 2003

SupercedesTN New new Effective date JUL 01 2002

STATE PLAN UNDER THE SOCIAL SECURITY ACT
STATE Commonwealth of Puerto Rico

OFFICIAL

**Methodology for Wrap around payments to Federally Qualified Health Centers/Rural Health Centers (FQHC/RHC)**

Wrap around payments to Federally Qualified Health Centers and Rural Health Centers serving Federally matched Medicaid beneficiaries in managed care plans will be made on a quarterly basis. Effective for managed care encounters provided on or after January 1, 2001, the amount of the wrap around will be calculated based on the FQHC/RHC PPS encounter rate. The FQHC/RHC will receive 100% of the difference between what it would have received under PPS and the revenues received from the managed care organization for services rendered to Federally matchable Medicaid beneficiaries. In the event that the revenues received from the managed care organization are equal to or in excess of what the FQHC/RHC would have received under PPS, no wrap around payment will be made. In the event that the Medicaid Agency erroneously overpays the FQHC/RHC (e.g., makes a wrap around payment when none was due), the provider must reimburse the Commonwealth for the amount of the overpayment within 90 days of being notified of the overpayment.

TN 02-01

Approved date APR 08 2003

SupercedesTN New

Effective date JUL 01 2002

8. Family Planning Services-

No reimbursement with FFP

9. Early and Periodic Screening, Diagnosis, and Treatment of Conditions Found-

Reimbursement either as out-patient clinic or inpatient hospital services on the basis of an all inclusive rate, except for screening services for which no FFP is presently claimed.

11. Transportation

Ambulance provided and reimbursed as part of all inclusive rate.
Other, provided but not reimbursed with FFP.

12. Home Health Services-

No reimbursement with FFP.

13a. Physical Therapy and related services

Limited to services provided in certain public facilities including contract facilities.
Reimbursement on basis of all inclusive outpatient or clinic rate.

13b. Occupational therapy

Limited to services provided in certain public facilities including contract facilities.
Reimbursement on the basis of all inclusive outpatient or clinic rate.

13c. Speech, hearing, and related services-

Limited to services provided in certain public facilities including contract facilities.
Reimbursement on the basis of an all inclusive outpatient or clinic rate.

14. Other diagnostic, etc.-

Limited to services provided in public facilities including contract facilities. Reimbursement on basis of all inclusive outpatient or clinic rate.

15. Emergency Hospital Services-

Limited to services provided on an outpatient basis in public facilities including contract facilities. Reimbursement on basis of all inclusive outpatient or clinic rate.

Citation

42 CFR 447, 434, 438, AND 1902 (a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Other Provider Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section(s) 4.19 B of this State Plan.

X Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

___ Additional Other Provider-Preventable Conditions identified below

Effective May 2, 2013 reimbursement for non-institutional services shall be based on the Provider Preventable Conditions (PPC) policy defined in 42 CFR 447.26.

In Puerto Rico, managed care entities and third party administrators' contract with provider and pay provider; there is no fee for service program. The managed care entities and third party administrators shall exclude payment for diagnoses not present on admission for any HCAC. The managed care entities are third party administrators shall report to Puerto Rico on the occurrence of HCACs, OPPCs and the corresponding reductions in payment on a [monthly] basis.

No payment shall be made for services for OPPCs. OPPC in one category of PPC as identified by the Centers for Medicare & Medicaid Services and apply broadly to any health care setting where an OPPC may occur. OPPCs include the three Medicare National Coverage Determinations: wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by the provider.

Reductions in provider payment may be limited to the extent that the following apply:

i. The identified PPC(s) would otherwise result in an increase in payment.
ii. The Territory can reasonably isolate for non-payment the portion of the payment directly related to treatment for, and related to, the PPC(s)

Non-payment of PPCs shall not prevent access to services for Medicaid beneficiaries.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Puerto Rico

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

---

Except for a nominal recipient copayment (as specified in Attachment 4.18 of this State plan), if applicable, the Medicaid agency uses the following general method for payment:

1. Payments are limited to State plan rates and payment methodologies for the groups and payments listed below and designated with the letters "SP".

   For specific Medicare services which are not otherwise covered by this State plan, the Medicaid agency uses Medicare payment rates unless a special rate or method is set out on Page 3 in item ___ of this attachment (see 3. below).

2. Payments are up to the full amount of the Medicare rate for the groups and payments listed below, and designated with the letters "MR."

3. Payments are up to the amount of a special rate, or according to a special method, described on Page 3 in item ___ of this attachment, for those groups and payments listed below and designated with the letters "NR".

4. Any exceptions to the general methods used for a particular group or payment are specified on Page 3 in item ___ of this attachment (see 3. above).

Not Applicable

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Puerto Rico

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

| | | | |
|---|---|---|---|
| QMBs: | Part A ____ Deductibles | ____ Coinsurance | |
| | Part B ____ Deductibles | ____ Coinsurance | |
| Other Medicaid Recipients | Part A ____ Deductibles | ____ Coinsurance | |
| | Part B ____ Deductibles | ____ Coinsurance | |
| Dual Eligible (QMB Plus) | Part A ____ Deductibles | ____ Coinsurance | |
| | Part B ____ Deductibles | ____ Coinsurance | |

Not Applicable

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Puerto Rico

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

Not Applicable

Attachment 4.19-D

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

OFFICIAL

State Commonwealth of Puerto Rico

No claims are being made for Federal matching for patients receiving nursing home services.

St. P.R. Tr. 11/12/76 Incorp. 12/17/76 Effective 12/31/76

79-6

Attachment 4.19 E

79-6

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of COMMONWEALTH OF PUERTO RICO

The definition of a claim for purposes of meeting the requirements of 42 CFR 447.45 is as follows:

for all services covered Under State Plan;

A Bill for Services.

P.R. Eff. 9/28/79 Issued 11/9/79 10-1-79

Attachment 4.20-A

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Commonwealth of Puerto Rico

Conditions for Direct Payment for Physicians and Dentists Services.

--- Not applicable. No direct payments are made under Title XIX.

PR 6/20/74 10/15/74 4/1/74

Revision: HCFA-PM-87-9 (BERC)
AUGUST 1987


OMB NO.: 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Puerto Rico

Requirements for Third Party Liability -
Identifying Liable Resources

1. The agency will perform matches specified in 42 CFR 433.138 (d) (1) on a monthly basis, in 433.138 (d) (3) on a continuing basis, and does not yet perform the matches in 433.138 (d) (4).

2. The agency follows on all match results immediately, but never later than 45 days. The information is then included in the master file.

3. At the time these matches are operationalized, the information will be added to the master file at once, but not later than 45 days. Since the provider of services is also the agency, new information on all other potential payers is immediately incorporated.

4. Since the agency is the provider, such services are identified upon admission and no claim is generated if these is another available payor. If new information regarding other payers is uncovered it is added in the file immediately, but never later than 45 days.





(ATT. 4.22 A PAGE 1&2)

Revision: HCFA-PM-87-9 (BERC)
AUGUST 1987


OMB NO.: 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Puerto Rico

Requirements for Third Party Liability -
Payment of Claims

Puerto Rico has established methods through which provides have to screen first for TPL payments where third party liability is known to exist, prior to submitting claims to Medicaid.

In the scarce cases where Medicaid has to seek third party reimbursement, input will be accepted in any amount offered.

In determining pursue of recovery for the Medicaid Program, the following threshold figures are used:

| Source of recovery | Amount |
|---|---|
| ( a ) Insurance such as: | |
| 1. Blue Cross | $500 |
| 2. Triple S | $500 |
| 3. Other Health Insurance | $500 |
| 4. Tort Liability | $500 |

Recovery in cases which fall below these figures will not be sought because pursuit of reimbursement has proven not to be cost effective.

Revision: HCFA-PM-91-8 (MB)
October 1991

ATTACHMENT 4.22-C
Page 1
OMB No.:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Puerto Rico

| Citation | Condition or Requirement |
|---|---|
| 1906 of the Act | State Method on Cost Effectiveness of Employer-Based Group Health Plans<br><br>Not Applicable |

TN No. 92-8
Supersedes
TN No. New

Approval Date OCT 14 1992

Effective Date JUL 1 1992

HCFA ID: 7985E

* U.S. Government Printing Office : 1991 - 312-149/40352

SUPPLEMENT TO ATTACHMENT 4.22

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Commonwealth of Puerto Rico

## STATE LAWS REQUIRING THIRD PARTIES TO PROVIDE COVERAGE ELIGIBILITY AND CLAIMS DATA

1902(A)(25)(I) The State has in effect laws that require third parties to comply with the provisions, including those which require third parties to provide the State with coverage, eligibility and claims data, of 1902(a)(25)(I) of the Social Security Act.

State/Territory: *Puerto Rico*

| Citation | Sanctions for Psychiatric Hospitals | |
|---|---|---|
| 1902(y)(1), 1902(y)(2)(A), and Section 1902(y)(3) of the Act (P.L. 101-508, Section 4755(a)(2)) | (a) | The State assures that the requirements of section 1902(y)(1), section 1902(y)(2)(A), and section 1902(y)(3) of the Act are met concerning sanctions for psychiatric hospitals that do not meet the requirements of participation when the hospital's deficiencies immediately jeopardize the health and safety of its patients or do not immediately jeopardize the health and safety of its patients. |
| 1902(y)(1)(A) of the Act | (b) | The State terminates the hospital's participation under the State plan when the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies immediately jeopardize the health and safety of its patients. |
| 1902(y)(1)(B) of the Act | (c) | When the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies do not immediately jeopardize the health and safety of its patients, the State may:<br>1. terminate the hospital's participation under the State plan; or<br>2. provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding; or<br>3. terminate the hospital's participation under the State plan and provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding. |
| 1902(y)(2)(A) of the Act | (d) | When the psychiatric hospital described in (c) above has not complied with the requirements for a psychiatric hospital within 3 months after the date the hospital is found to be out of compliance with such requirements, the State shall provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the end of such 3-month period. |

*Not Applicable*

State: [Puerto Rico]

| Citation | Sanctions for MCOs and PCCMs |
|---|---|
| 1932(e)<br>42 CFR 438.726 | (a) The State will monitor for violations that involve the actions and failure to act specified in 42 CFR Part 438 Subpart I and to implement the provisions in 42 CFR 438 Subpart I, in manner specified below: |

Pursuant to the terms and conditions of Commonwealth's Law 72 of November 7, 1993 and the existing Cooperative Agreement with the Department of Health, the Puerto Rico Health Administration (PRHIA) monitors violations for actions and failures as specified under 42CFR Part I 438 in accordance with the process and procedures set forth on the MCOs and PIHPs contracts and through the Plan Compliance Program's work plan, which serves as an instrumental tool for all programmatic and contract provisions monitoring.

Intermediate Sanctions: The PRHIA may impose intermediate sanctions to MCOs and PIHPs if they engage in any of the practices as set forth:

(1) Fails to substantially provide medically necessary services to enrollees under this contract;
(2) Imposes on enrollees premiums and charges in excess of the ones permitted under this contract;
(3) Discriminates among enrollees on the basis of their health status or requirements for health care (such as terminating an enrollment or refusing to reenroll) except as permitted under the Program or engages in practices to discourage enrollment by recipients whose medical condition or history indicates need for substantial medical services;
(4) Misrepresents or falsifies information that is furnished to CMS, to the PRHIA, to an enrollee, potential enrollee or provider of services;
(5) Distributes, directly or indirectly through any agent, independent contractor, marketing material not approved by the PRHIA, or that contains false or misleading information;
(6) Fails to comply with the requirements for physician incentive plans in section 1876 (i) (8) of the Social Security Act, and at 42 CFR 417.479, or fails to submit to the PRHIA its physician incentive plans as requested in 42 CFR 438.6(h);
(7) Has violated any other applicable requirements of section 1903(m) or 1932 of the Social Security Act and any implementing regulations.

State: [Puerto Rico]

Types of intermediate sanctions the PRHIA may impose:

The following types of intermediate sanctions may be imposed: Civil monetary penalties, termination, temporary management and granting enrollees the right to terminate enrollment without cause and notifying the affected enrollees of their right to disenroll; suspension of all new enrollment, including default enrollment after effective date of a sanction; suspension of payment for enrollees after the effective date of the sanction and until CMS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur and temporary management.

Sanctions for MCOs and PCCMs

Civil Monetary Penalties(CMP) amounts thresholds are the following:

(i) Between ($500) to a maximum of ($25,000) dollars for each determination of failure to provide services; misrepresentation or false statements to enrollees, potential enrollees or health care providers; failure to comply with physician incentive plan requirements; or marketing violations; or engages in behavior contrary to any requirements of section 1903(m) and 1932 of the Social Security Act and any implementing regulations;

(ii) A maximum ($100,000) for each determination of discrimination, or misrepresentation, or false statements to CMS or the PRHIA pursuant to 438 CFR 704(b) (2);

(iii) A maximum ($15,000) per incident up to a maximum of $100,000 for each enrollee that was not enrolled because of a discriminatory practice;

(iv) A maximum ($25,000), or double amount of excess charges, whichever is greater, for charging premiums or charges in excess of amounts permitted under Medicaid regulations.

(b) The State uses the definition below of the threshold that would be met before an MCO is considered to have repeatedly committed violations of section 1903(m) and thus subject to imposition of temporary management:

Special Rule: Temporary management only if it finds that egregiously or repeatedly behavior have been engaged in any of the stated practices on paragraph (a) of this article; or places a substantial risk on the health of enrollees; or engages in behavior contrary to any requirements of sections 1903(m) and 1932 of Title XIX , or there is a need to assure the health and safety of enrollees during an orderly termination, reorganization of the MCO, or while improvements are being made to correct violations. When imposing temporary management PRHIA must permit enrollees the right to terminate enrollment without cause, as described in 42 CFR 438.702(a) (3) and must notify enrollees of their right to disenroll.

State: [Puerto Rico]

(c) The State's contracts with MCOs provide that payments provided for under the contract will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by CMS under 42 CFR 438.730(e).

___ Not applicable; the State does not contract with MCOs, or the State does not choose to impose intermediate sanctions on PCCMs.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Commonwealth of Puerto Rico

## 4.32 Income and Eligibility Verification System

The Medicaid agency has established a system for income and eligibility verification in accordance with the requirements of 42 CFR 435.940 through 435.960. **(Section 1137 of the Act and 42 CFR 435.940 through 435.960)**

(c) ATTACHMENT 4.32-A describes in accordance with 42 CFR 435.948(a)(6) the information that will be requested in order to verify eligibility or the correct payment amount and the agencies and the State(s) from which that information will be requested.

The State has an eligibility determination system that provides for data matching through the Public Assistance Reporting Information System (PARIS), or any successor system, including matching with medical assistance programs operated by other States. The information that is requested will be exchanged with States and other entities legally entitled to verify title XIX applicants and individuals eligible for covered title XIX services consistent with applicable PARIS agreements.

Revision: HCFA-PM-86-9 (BERC)
MAY 1986

OFFICIAL

ATTACHMENT 4.32-A
Page 1
OMB NO.: 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Territory: PUERTO RICO

INCOME AND ELIGIBILITY VERIFICATION SYSTEM PROCEDURES
REQUESTS TO OTHER STATE AGENCIES

TN No. 86-2
Supersedes
TN No. NEW

Approval Date MAR. 17 1987

Effective Date SEP. 5 1986

HCFA ID: 0124P/0002P

☆U.S. GOVERNMENT PRINTING OFFICE: 1986 491 264 42132

OFFICIAL

Revision: HCFA-PM-87-4 (BERC)
MARCH 1987

ATTACHMENT 4.33-A
Page 1
OMB No.: 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Puerto Rico

METHOD FOR ISSUANCE OF MEDICAID ELIGIBILITY CARDS
TO HOMELESS INDIVIDUALS

Cards are not mailed to recipients, they are issued at interview at the local eligibility unit.

[redacted]

TN No. 88-1
Supersedes
TN No. NEW

Approval Date [illegible] 10/20/89

Effective Date 4/1/88

HCFA ID: 1080P/0020P

Revision: HCFA-PM-91-9 (MB) OMB No.:
October 1991

State/Territory: [Puerto Rico]

# REQUIREMENTS FOR ADVANCE DIRECTIVES UNDER STATE PLANS FOR MEDICAL ASSISTANCE

The following is a description of the law of the state (whether statutory or recognized by courts of the state) concerning advance directives. If applicable States should include definitions of living will, durable power of attorney for health care, durable power of attorney, witness requirements, special State limitations on living will declarations, proxy designation, process information and State forms, and identify whether law allows for a health care provider or agent of the provider to object to implementation of advance directives on the basis of conscience.

Public Law No. 160, is the state law establishing the policies and procedures related to advance directive for the Commonwealth of Puerto Rico, it was approved on November 17, 2001. In general terms, it acknowledges the right of capable adults to make decisions concerning medical or surgical treatment, such as refusing or, accepting a treatment and instructing designated representatives with advance directives of treatment in the event of suffering terminal health conditions or persistent vegetative state through a durable power of attorney designation. The Act stipulates the purposes, procedures, qualifications for the representative's designation and other documentation requirements that are to be followed by the medical and institutional providers for the compliance with the mandated right and its implementation. It does not expressly provide for objection on the basis of conscience by provider nor agent, although it expressly emphasizes the criteria and principle that the statute does not authorize euthanasia or death by mercy.

Revision: HCFA-PM-90- 2 (BPD)
JANUARY 1990

ATTACHMENT 4.35-A
Page 1
OMB No.: 0938-0193

OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Puerto Rico

CRITERIA FOR THE APPLICATION OF SPECIFIED REMEDIES FOR SKILLED NURSING AND INTERMEDIATE CARE FACILITIES
(When and how each remedy is applied, the amounts of any fines, and the severity of the remedies)

At present, we are not paying skilled nursing facilities.

Puerto Rico will indicate compliance with skilled nursing facilities requirements at the future, when and if they are developed.

TN 90-1 Approval Date AUG 22 1990

Supersedes TN NEW Effective Date APR 01 1990

Revision: HCFA-PM-90- 2 (BPD)
JANUARY 1990

OFFICIAL

ATTACHMENT 4.35-B
Page 1
OMB No.: 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Puerto Rico

ALTERNATIVE REMEDIES TO SPECIFIED REMEDIES FOR SKILLED NURSING AND INTERMEDIATE CARE FACILITIES

At the time and if Puerto Rico establishes a skilled nursing facility, we will present the alternatives to specified remedies.

TN 90-1 Approval Date AUG 22 1990

Supersedes TN NEW Effective Date APR 01 1990

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Puerto Rico

DISCLOSURE OF ADDITIONAL REGISTRY INFORMATION

OFFICIAL

Revision: HCFA-PM-91-10 (BPD)



STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Puerto Rico

COLLECTION OF ADDITIONAL REGISTRY INFORMATION



* U.S. Government Printing Office : 1991 - 312-149/40413

Revision: HCFA-PM-93-1 (BPD)
January 1993

OFFICIAL



STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: *Puerto Rico*

DEFINITION OF SPECIALIZED SERVICES

*Not Applicable*

OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Puerto Rico

CATEGORICAL DETERMINATIONS

Not Applicable



* U.S. G.P.O.:1993-342-239:80013

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Puerto Rico

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Survey and Certification Education Program

The State has in effect the following survey and certification periodic educational program for the staff and residents (and their representatives) of nursing facilities in order to present current regulations, procedures, and policies.

Not Applicable

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Puerto Rico

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for the Investigation of Allegations of Resident Neglect and Abuse and Misappropriation of Resident Property

The State has in effect the following process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide or a resident in a nursing facility or by another individual used by the facility in providing services to such a resident.

Not Applicable

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Puerto Rico

ELIGIBILITY CONDITIONS AND REQUIREMENTS

## Procedures for Scheduling and Conduct of Standard Surveys

The State has in effect the following procedures for the scheduling and conduct of standard surveys to assure that it has taken all reasonable steps to avoid giving notice.

Not Applicable

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Puerto Rico

ELIGIBILITY CONDITIONS AND REQUIREMENTS

## Programs to Measure and Reduce Inconsistency

The State has in effect the following programs to measure and reduce inconsistency in the application of survey results among surveyors.

Not Applicable

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Puerto Rico

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for Investigations of Complaints and Monitoring

The State has in effect the following process for investigating complaints of violations of requirements by nursing facilities and monitors onsite on a regular, as needed basis, a nursing facility's compliance with the requirements of subsection (b), (c), and (d) for the following reasons:

(i) the facility has been found not to be in compliance with such requirements and is in the process of correcting deficiencies to achieve such compliance;

(ii) the facility was previously found not to be in compliance with such requirements and has corrected deficiencies to achieve such compliance, and verification of continued compliance is indicated; or

(iii) the State has reason to question the compliance of the facility with such requirements.

Not Applicable

ATTACHMENT 4 42-A
Employee Education About
False Claims Recoveries

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Commonwealth of Puerto Rico

OFFICIAL

METHOLODOLGY FOR THE IMPLEMENTATION OF THE EMPLOYEE EDUCATION ABOUT FALSE CLAIMS ACT

The Department of Health, as the Single State Agency, instructs its sub-grantee, the Puerto Rico Health Insurance Administration (ASES), to require all contracted entities, no later than June 15, 2010; to provide evidence of compliance with Section 1902(a)(68) of the Social Security Act. For calendar years 2007, 2008 and 2009, all entities who in federal fiscal years (FFY) 2006, 2007 and 2008 met the $5,000,000 dollar annual threshold, attest certifying to the fact that they were in compliance with Section 1902(a)(68) of the Social Security Act.

For subsequent years beginning with calendar year 2010, the Puerto Rico Health Insurance Administration, on behalf of the Single State Agency, will require that all contracted entities who meet the $5,000,000 dollar threshold as of September 30th, provide the items listed below no later than December 30, of each year as evidence of compliance with Section 1902(a)(68) of the Social Security Act. Contracted entities who fail to comply with these requirements will be fined by the ASES.

a) Acknowledgment of Compliance with Section 1902(a)(68) of the Social Security Act.
b) Copy of Policies and Procedure developed to comply with Section 1902(a)(68) of the Social Security Act. A copy of the employee handbook should also be provided if the contracted entity has an employee handbook.

The ASES will provide the Single State Agency a copy of each document listed above from each contracted entity who meets the requirements.

TN No. 07-12
Supersedes
TN No. _____

Approval Date APR 16 2010 Effective Date JAN 01 2007

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Commonwealth of Puerto Rico

4.46 Provider Screening and Enrollment

| Citation | |
|---|---|
| 1902(a)(77)<br>1902(a)(39)<br>1902(kk);<br>P.L. 111-148 and<br>P.L. 111-152 | The State Medicaid agency gives the following assurances: |
| 42 CFR 455 Subpart E | PROVIDER SCREENING<br>_____Assures that the State Medicaid agency complies with the process for screening providers under section 1902(a)(39), 1902(a)(77) and 1902(kk) of the Act. |
| 442 CFR 455.410 | ENROLLMENT AND SCREENING OF PROVIDERS<br>_____ Assures enrolled providers will be screened in accordance with 42 CFR 455.400 et seq.<br>_____Assures that the State Medicaid agency requires all ordering or referring physicians or other professionals to be enrolled under the State plan or under a waiver of the Plan as a participating provider. |
| 42 CFR 455.412 | VERIFICATION OF PROVIDER LICENSES<br>_____Assures that the State Medicaid agency has a method for verifying providers licensed by a State and that such providers licenses have not expired or have no current limitations. |
| 42 CFR 455.414 | REVALIDATION OF ENROLLMENT<br>_____Assures that providers will be revalidated regardless of provider type at least every 5 years. |
| 42 CFR 455.416 | TERMINATION OR DENIAL OF ENROLLMENT<br>_____Assures that the State Medicaid agency will comply with section 1902(a)(39) of the Act and with the requirements outlined in 42 CFR 455.416 for all terminations or denials of provider enrollment. |
| 42 CFR 455.420 | REACTIVATION OF PROVIDER ENROLLMENT<br>_____Assures that any reactivation of a provider will include re-screening and payment of application fees as required by 42 CFR 455.460. |
| 42 CFR 455.422 | APPEAL RIGHTS<br>_____Assures that all terminated providers and providers denied enrollment as a result of the requirements of 42 CFR 455.416 will have appeal rights available under procedures established by State law or regulation. |

42 CFR 455.432 SITE VISITS

_____ Assures that pre-enrollment and post-enrollment site visits of providers who are in "moderate" or "high" risk categories will occur.

42 CFR 455.434 CRIMINAL BACKGROUND CHECKS

_____ Assures that providers, as a condition of enrollment, will be required to consent to criminal background checks including fingerprints, if required to do so under State law, or by the level of screening based on risk of fraud, waste or abuse for that category of provider.

42 CFR 455.436 FEDERAL DATABASE CHECKS

____ Assures that the State Medicaid agency will perform Federal database checks on all providers or any person with an ownership or controlling interest or who is an agent or managing employee of the provider.

42 CFR 455.440 NATIONAL PROVIDER IDENTIFIER

____ Assures that the State Medicaid agency requires the National Provider Identifier of any ordering or referring physician or other professional to be specified on any claim for payment that is based on an order or referral of the physician or other professional.

42 CFR 455.450 SCREENING LEVELS FOR MEDICAID PROVIDERS

____ Assures that the State Medicaid agency complies with 1902(a)(77) and 1902(kk) of the Act and with the requirements outlines in 42 CFR 455.450 for screening levels based upon the categorical risk level determined for a provider.

42 CFR 455.460 APPLICATION FEE

____ Assures that the State Medicaid agency complies with the requirements for collection of the application fee set forth in section 1866(j)(2)(C) of the Act and 42 CFR 455.460.

42 CFR 455.470 TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PROVIDERS OR SUPPLIERS

____ Assures that the State Medicaid agency complies with any temporary moratorium on the enrollment of new providers or provider types imposed by the Secretary under section 1866(j)(7) and 1902(kk)(4) of the Act, subject to any determination by the State and written notice to the Secretary that such a temporary moratorium would not adversely impact beneficiaries' access to medical assistance.

Attachment 7.2-A

OFFICIAL

State: Commonwealth of Puerto Rico

Methods of Administration: Civil Rights

The Civil Rights of all persons in need of services under Title XIX are protected by the Bill of Rights of the constitutions of the United States and of the Commonwealth of Puerto Rico.

Article II, of the Constitution of the Commonwealth of Puerto Rico defines the specific rights of citizens.

St. PR Tr. 6/20/74 Incorp. 10/15/74 Effective 4/1/74

**Exhibit B**

**Puerto Rico Department of Health PPS Manual**

# Reimbursement Ruling Federally Qualified Health Centers (FQHC)

## MEDICAID PROGRAM

PUERTO RICO DEPARTMENT OF HEALTH

2019

# Reimbursement Ruling

# 1. General Provisions

## 1.1 Background

Federally qualified health centers (FQHCs) are primary care clinics first established in 1965 as part of President Lyndon Johnson's War on Poverty. Located in underserved areas, they maintain an "open door" policy, providing care regardless of an individual's ability to pay. Consequently, they serve a disproportionate share of uninsured individuals and Medicaid beneficiaries.

In 1975, the federal authorities passed a special Community Health Center program which was authorized under Section 330 of the Public Health Service Act. This program included a few points that helped the public understand the basic purpose of these centers and this clarification helped the centers understand their rights and duties. These facilities were defined as sites for comprehensive primary care. The centers were supposed to involve the local community and deliver high-quality primary care with the help of qualified, trained professional staff.

FQHCs include community health centers, migrant health centers, health care for the homeless health centers, public housing primary care centers, and health center program "look-alikes." They also include outpatient health programs or facilities operated by a tribe or tribal organization or by an urban Indian organization. FQHCs are paid based on the FQHC Prospective Payment System (PPS) for medically-necessary.

On December 21, 2000 the President of the United States signed the "Medicare, Medicaid, and SCHIP Benefits Improvement Act of 2000" (BIPA). This Act brought forth a prospective payment methodology (PPS) to establish a minimum Medicaid per visit rate.[1]

The Prospective Payment System (PPS) established by BIPA required that FQHCs be reimbursed at a minimum rate provided to Medicaid beneficiaries. The previous cost-based reimbursement systems made payments to the health centers after the service had been performed. The new PPS established a payment rate for a service before the service is delivered. This PPS rate is determined individually for each FQHC. The Act also established that this base rate would be adjusted yearly by the percentage increase in the Medicare Economic Index (MEI) and adjusted to take into account any increase or decrease in the scope of services provided by the Center.[2]

1 42 USC 1396a(bb)(1-3).
2 42 USC 1396a(bb)(3)(a-b)

## 1.2 Definitions

The following words and terms, when use in this chapter, shall have the following meanings, unless the context indicates otherwise:

**"HEALTH CENTER" -** An entity that serves a population that is medically underserved, or a special medically underserved population comprised of migratory and seasonal agricultural workers, the homeless, and residents of public housing, by providing, either through the staff and supporting resources of the center or through contracts or cooperative arrangements.

**"THE PROSPECTIVE PAYMENT SYSTEM (PPS)" –**is a method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service (for example, diagnosis-related groups for inpatient hospital services). CMS uses separate PPSs for reimbursement to acute inpatient hospitals, home health agencies, hospice, hospital outpatient, inpatient psychiatric facilities, inpatient rehabilitation facilities, long-term care hospitals, and skilled nursingfacilities.

**"INDEPENDENT CLINIC" –** Includes, but not limited to, clinic such as ambulatory care facility, ambulatory surgical center, ambulatory care/family planning clinic and federally qualified center.

**"ENCOUNTER"** - An encounter is defined as a face to face event between a patient and an FQHC provider of health care services who exercises independent judgment when providing health services to the patient. A rendering practitioner may be a physician, clinical psychologist, psychiatrist, dentist, or clinical social worker employed by or holding a contract directly with the FQHC and providing a service as defined in 42 U.S.C §1396d(a)(2)(C).

**"VISIT"** - A visit is defined as one or more related encounters. Related encounters may or may not occur on the same day. For a health service to be defined as a Medicaid/CHIP visit, it must be included in the FQHC's defined scope of services as approved by Puerto Rico and billed under the FQHC's provider number. All services must be documented in the beneficiary's medical record in order to qualify for a visit. An FQHC cannot obtain reimbursement for more than one (1) visit per day for each beneficiary unless there are two (2) separate visits with two (2) separate diagnoses. Ancillary services provided without a face-to-face visit as defined above, do not constitute a visit.

**"ASES"** – Administación de Seguros de Salud de Puerto Rico as it's known by its Spanish – language acronym.

## 1.2 Scope of Service

This booklet describes the ruling for the Prospective Payment System (PPS) program for the Medicaid Program in Puerto Rico.

Medically necessary services provided in an independent clinic setting shall meet all applicable state and Federal Medicaid laws, and all applicable policies, rules and regulations as specified in the appropriated provides service manual for the PR Medicaid Program. Failure to comply with the mentioned regulations could delay payments as required, cancellations, and any other guideline that the law may provide PR Medicaid Program to exercise.

## 1.3 Federally Qualified Health Centers

In 1989, Congress amended the Social Security Act to include a new provider type known as the Federally Qualified Health Center (FQHC or the Center).[3] FQHCs qualify for enhanced reimbursement from Medicare and Medicaid, as well as other benefits. FQHCs must fall under one of the following categories:

a. receiving grants under Title 42, Chapter 6A, Subchapter II, Part D, subpart I, section 254b of the U.S. Code (formerly known as Section 330 of the Public Health Services Act);
b. receiving the grants referenced above based on the recommendation of the Health Resources and Services Administration within the Public Health Service, as determined by the Secretary, to meet the requirements for receiving such a grant, or
c. a tribe or tribal organization operating outpatient health programs or facilities under the Indian Self-Determination Act.

An FQHC is unique only in the way it is paid for services eligible for a visit payment, not by the scope of coverage for which it is paid. An entity with multiple sites may be designated as a single FQHC, or each site may be designated as an individual FQHC, depending on the designation by the US Department of Health & Human Services (DHHS).

Participation in the FQHC program is voluntary. Puerto Rico allows only DHHS designated FQHCs to participate in its FQHC program. Participating FQHCs receive payment only for services provided to clients enrolled in Title XIX (Medicaid) or Title XXI (CHIP). Nonparticipating DHHS designated FQHCs receive reimbursement on a fee for service basis.

The Health Centers Consolidation Act of 1996 consolidated and reauthorized provisions relating to health centers. It defines health centers as an entity that serves a population that is medically underserved, or a special medically underserved population comprised of migratory and seasonal workers, the homeless, and residents of public housing, by providing a set of required services, either through the staff and supporting resources of the center, through contracts or other cooperative arrangements.[4] In Puerto Rico, several municipalities have been designated as medically

2 Federal Community Health Centers and State Health Policies: A Primer for Policy Makers, June 2008. 4 Section 330(a)(1) of the Health Centers Consolidation Act of 1996.

underserved areas since 1978.[5] In 1993, the first Federally Qualified Health Center was established in Puerto Rico.[6]

## 2. Puerto Rico FQHC

The Puerto Rico Department of Health is responsible for developing, implementing, and managing the State Plan that defines the PR Medicaid Program. Within the Department of Health, the PR Medicaid Program administers and is responsible for determining beneficiary eligibility as well as investigating beneficiary fraud and abuse. In 1993, Puerto Rico passed legislation authorizing an island-wide managed care program predominantly for low income citizens, including Medicaid beneficiaries. As part of this legislation, an interagency collaborative agreement was established to delegate implementation of the law to a new government entity, the Puerto Rico Health Insurance Administration (ASES). ASES was given the responsibility for contracting with insurance companies and overseeing the operations of the Commonwealth's managed care program.

Through ASES, Puerto Rico then provides services to Medicaid beneficiaries through a contract with a Managed Care Organization (MCOs). An MCO is a health plan insurance company with its own group of physicians and other providers that work together to provide medical services to its members. Puerto Rico contracts health insurance companies to whom it pays a fixed monthly rate per Medicaid beneficiary. The health insurance company will then cover all authorized (WAP). Wraparound payments are to be made pursuant to a payment schedule agreed by Puerto Rico and the FQHC, but in no case less frequently than every four (4) months.[7] Puerto Rico pays wraparound payments quarterly.

The PPS Office, at the PR Medicaid Program, determines FQHC reimbursement based on the Medicaid State Plan approved by CMS. The services covered are for outpatient ambulatory services included in each FQHC's approved scope of services. CMS only permits reimbursement based upon reasonable costs for services defined in the Puerto Rico Title XIX State Plan for outpatient ambulatory services as defined in Section 1861 (aa)(1) (A) – (C) of the Social Security Act which lists FQHC required core services. Reimbursement is <u>not</u> permitted for costs of health care services not in the Puerto Rico Title XIX State Plan; as defined in the FQHC required core services; as approved in each FQHC's scope of services.

[5]See http://muafind.hrsa.gov/index.aspx for a complete list of Medically Underserved Areas (MUA) in Puerto Rico and their year of designation.

6Prospective Payment System Manual, Department of Health, May 1996.

[7]42 USC 1396a(bb)(5b).

Under BIPA, Puerto Rico is obliged to make supplemental payments to the FQHCs for the difference between the payment received by the FQHC for treating the MCO enrollee and the payment to which the FQHC would be entitled for these visits under the PR Medicaid Program of PPS.[8] This supplemental payment is also known as a wraparound payment.

## 2.1 FQHC reimbursement (Dual eligible individuals)

FQHCs are entitled to PPS reimbursement for services provided to any individual eligible for Medicaid regardless of the existence of third partythird-party liability including Medicare. However, regular third partythird-party liability collections and payments still apply and reduce the amount of PPS payments due from Puerto Rico. Generally, Medicaid managed care providers must first request Medicare interim payments and reconciliations to then request Medicaid PPS payment and reconciliations once Medicare has paid for its services. If the provider participates with an MCO that is a Medicaid plan as well as a Medicare Advantage (MA) plan, then there are two separate reconciliations that must occur for each FQHC.

Generally, in Medicare fee-for-service delivery systems, Medicare pays providers an interim payment that is based on the all-inclusive rate per visit established by the Medicare Fiscal Intermediary (FI). The rate is paid, subject to the Medicare deductible and coinsurance requirements, for each covered visit with a Medicare beneficiary. No Medicare deductible applies to FQHC services provided at FQHCs. Only FQHC services are exempt from the deductible.[9] At the end of the reporting period, RHCs/FQHCs receive an annual reconciliation payment from the FI.[10] Because of Medicare payment limits, it is possible that the Medicare per visit cost reconciliation amount is less than the Medicaid PPS per visit payment amount and Medicaid would pay the difference between the PPS rate and Medicare rate.

In Medicare Advantage health delivery systems, an FQHC is only eligible to receive a supplemental payment when FQHC services are provided during a face-to-face visit between a Medicare Advantage (MA) enrollee and one or more of the following FQHC covered core practitioners: physicians, nurse practitioners, physician assistants, certified

8 42 USC 1396a(bb)(5)(a) and a letter from Mr. Timothy M. Westmoreland, CMS Director, to State PR Medicaid Program Director dated January 19, 2001 regarding initial guidance on the new Medicaid PPS methodology.

[9] The Medicare payment rate is calculated, in general, by dividing the total allowable cost by the number of total visits for RHC/FQHC services.

[10] The FQHCs report to the FI the actual allowable costs and actual visits for RHC/FQHC services for the reporting period. Also RHCs/FQHCs submit any other information as may be required. After reviewing the report, the FI divides actual allowable costs by the number of actual visits to determine a final rate for the period. Both the final rate and the interim rate are subject to screening guidelines for evaluating the reasonableness of the clinic's productivity, a payment limit, and psychiatric services limit. The FQHC payment methodology also includes one urban and one rural payment limit above which the FI will not pay. The FI compares the total payment due with the total payments made for services furnished during the reporting period. If the total payment due exceeds the total payments made, the RHC/FQHC has been underpaid. The underpayment is made up by a lump sum payment. If the total payment due is less than the total payments made, the RHC/FQHC has been overpaid for services furnished to Medicare patients. Overpayments are deducted from future payments or invoiced to the FQHC, if no further payment is due.

nurse midwives, clinical psychologists, or clinical social workers. The supplemental payment is made directly to each qualified FQHC through the Medicare FI. Each FQHC seeking the supplemental payment is responsible for submitting a claim for each qualifying visit to the FI for the amount of the interim supplemental payment rate (FQHC interim all-inclusive rate – estimated average payment from the MA plan plus any beneficiary cost sharing = billed amount > 0). Any receipts from Medicare for a Medicaid dual eligible individual - whether for an interim payment, an annual reconciliation, or a Medicare Advantage wraparound payment - must be reported in the Medicaid reconciliation and must offset the PR Medicaid Program PPS payments for which the FQHC is entitled.

## 3. Payment Determination (Formula)

At the end of each quarter, the PR Medicaid Program will make a wraparound payment and a subsequent reconciliation wraparound payment to each FQHC. These payments will be determined using the wraparound payment formula. This formula has both cost and income components. The following is the wraparound payment formula that will be used by the PR Medicaid Program to determine if a wraparound payment is needed:

| | | | | |
|---|---|---|---|---|
| **Cost** | | | | |
| Visits for the Period (#) | x | PPS Rate ($) | = | Total Costs related to Medicaid Beneficiaries |
| **Income** | | | | |
| Net Capitation Payment for the Period + Fee for Services received by the FQHC as a Provider + Other Payments Received to offset direct costs of providing FQHC services | x | % of Medicaid Beneficiaries assigned to the Center | = | Total Income related to Medicaid Beneficiaries |
| **Wraparound Payment** | | | | |
| Total Costs related to Medicaid Beneficiaries | > | Total Income to Medicaid Beneficiaries | = | The excess of Costs over Income represents the Wraparound Payment |

| | | | | |
|---|---|---|---|---|
| Total Costs related to Medicaid Beneficiaries | < | Total Income to Medicaid Beneficiaries | = | No Wraparound Payment |

Each quarter, the PR Medicaid Program will pay the FQHCs a preliminary wraparound payment based on the average of the two previous quarter's wraparound payments. This payment must be made no later than thirty (30) days after the end of the quarter.

The PR Medicaid Program will then calculate the actual wraparound payment due for that given quarter within one hundred and twenty (120) days (4 months) of the end of the quarter, to allow data to complete. For this reconciliation, the wraparound formula will be the same except that an additional step will be added to the computation to consider preliminary payment. This additional step is as follows:

| **Wraparound Payment Additional Step for Reconciliation Purposes** | | | | |
|---|---|---|---|---|
| Excess of Costs over Income | > | Initial Payment | = | Wraparound payment as a result of the Reconciliation. |
| Excess of Costs over Income | < | Initial Payment | = | The excess of Initial Payment represents an amount owed by the FQHC and reimbursable to The PR Medicaid Program |
| Excess of Income over Costs | | | | If a payment was made to the FQHC during the initial computation, the total amount should be reimbursed to The PR Medicaid Program. |

Once the WAP is determined the FQHC will be notified of the amount. If the preliminary payment:

- Exceeds the actual WAP, the PR Medicaid Program will deduct any excess form future payments or invoiced to the FQHC if no further payment is due.
- Is less than the actual WAP, the PR Medicaid Program will pay the difference to the FQHC within thirty (30) days of the notification.

When unusual and infrequent circumstances so require or in the case that the MCO has failed to provide the necessary documentation, the PR Medicaid Program will have an additional thirty (30) days to calculate the WAP due.

### 3.1 Multiple Provider Numbers

Each FQHC will be assigned a provider number. If an FQHC has several clinic sites, a provider number may be issued for each site. An FQHC **must use** appropriate the provider number(s) when billing to receive payment under the FQHC visit reimbursement system. Regardless of the number of sites or provider numbers assigned to each site, the FQHC will be considered a single entity for reimbursement purposes and all services provided by all entities under that FQHC will be reimbursed at the single PPS rate applicable to that FQHC.

## 4. Components of the Wraparound Payment Formula

The following section describes each component of the wraparound formula. The components are:

- Number of Medicaid Beneficiaries Visits
- Prospective Payment System (PPS) Rate and Medicare Economic Index
- Income related to Medicaid Patients and Allocation for Medicaid Beneficiaries

### 4.1 Number of Medicaid Beneficiaries Visits

The FQHC reimbursement structure is based on a per visit basis, with individual visit rates established for each FQHC. For reimbursement purposes, a provider receives the Prospective Payment System (PPS) rate payment when a **visit** occurs, not to be confused with an **encounter.** The reimbursement is made for costs related to Medicaid's patient visits. That is why is important to define the difference between an encounter and a visit as it pertains to the calculation of the PPS rate and the wraparound payment.

#### 4.1.1 How do I determine whether an encounter is a visit?

To determine whether an encounter with a patient meets the visit definition, all the following criteria must be met:

1. Independent Judgment: The provider must make an independent judgment. The provider must act independently and not assist another provider.

   Examples:

   - Visit: A primary care physician (i.e., internal medicine, pediatrician, etc.) sees a patient to monitor physiological signs and to provide medication.
   - Not a Visit: A nurse assists a physician during a physical examination by taking vital signs, history, or drawing a blood sample.

2. Documentation: All services provided must be documented in the patient's medical record. The patient's medical visit does not have to be documented with a full and complete health record to meet the visit

criteria. It is acceptable to simply document the services provided in the patient's medical record. Emergency services may be billed as a visit when minimal services are provided even though a complete health record is not created.

3. Each individual provider is limited to one type of visit per day for each patient, regardless of the services provided.

   Example: A physician may not bill for a medical visit and a mental health visit for the same patient on the same day. When an all-inclusive service (e.g., CPT code 59400) is billed, the subsequent visit cannot be billed with an Evaluation and Management (E/M) code and visit. (CPT procedure codes and descriptions are copyrighted by the American Medical Association [2006].)

   A dental visit and a physician visit can be billed separately on the same day by using separate diagnoses codes. In addition, if a patient visits a health center, more than one visit will be allowed if there are two different practitioners with two different specialties performing the services.

4. Serving Multiple Patients Simultaneously - When a provider renders services to several patients simultaneously, the provider can count a visit for each patient if the services are documented in each patient's health record. This also applies to family therapy and family counseling sessions. The provider must bill each service for each patient on separate claim forms.

### 4.1.2 For what types of services may a visit be documented?

The health service provided during the visit must constitute an allowable outpatient ambulatory service under the PR Medicaid Program of State Plan; as defined in Section 1861 (aa) (1) (A)-(C) of the SSA which lists FQHC required core services; as approved by Puerto Rico in the FQHC's approved scope of services for:

- The ongoing, continuous, or repetitive management of the patient's health care, inclusive of services and supplies; and
- The overall coordination of all services provided to the patient.

| FQHC Services in Statute | Puerto Rico Medicaid Coverage |
|---|---|
| **Preventive Services** | |
| Preventive Services | To extent covered in Medicaid Program State Plan |
| **FQHC Core Services** | |
| Physician Services | Included |
| Mid-Level Practitioner (Physician Assistants (Pas), Advanced Registered Nurse Practitioners (ARNPs), and Certified Nurse Midwives (CNM)) Services | PAs, ARNPs, and CNM licenses do not exist in Puerto Rico |

| FQHC Services in Statute | Puerto Rico Medicaid Coverage |
|---|---|
| Clinical Psychologist Services | Included |
| Clinical Social Worker Services (CSWs) | Included |
| Services and Supplies "Incident to" Covered Services | Included (Do not result in a separate visit). |
| Visiting Nurse Home Health Services (in designated areas where there is a designated shortage of home health agencies) | Home Health Service is not a Medicaid covered services in Puerto Rico |
| **Other Services** | |
| Hospital Care | As covered in State Plan for outpatient ambulatory services |
| Nursing Home Care | Nursing Home Care is not a Medicaid service in Puerto Rico |
| Other Ambulatory Services | "Other ambi" services include: blood draws, lab tests, x-rays, prescriptions, and optical services (Do not result in a separate visit).<br>Dental (may be billed as a visit) |
| Diabetes Self-Management Training Services and Medical Nutrition Therapy Services | As covered in State Plan as outpatient ambulatory services |
| EPSDT | Included |

### 4.1.3 Types of services that do NOT qualify as visits

Any service reimbursed outside of Medicaid/Chip including, but not limited to, health services provided to patients under Puerto Rico-only programs (e.g., "Vital"). There are services that are not visits in and of themselves, but these services may be provided in addition to other medical services as part of a visit.

**Note:** Record an appropriate visit for ALL eligible patient claims (e.g., Medicaid/CHIP, Medicare, Commonwealth, private pay).

### 4.1.4 FQHC-Related Activities NOT covered

The following activities and costs are **NOT** covered by Medicaid/CHIP and **CANNOT** be billed as a visit:

1. Participation in a community meeting or group session that is not designed to provide health services. Examples: Informational sessions for prospective patients, health presentations to community groups, high school classes, PTAs, etc. or informational presentations about available FQHC health services.

2. Health services provided as part of a large-scale effort.

Examples: Mass-immunization program, screening program, or a community-wide service program (e.g., a health fair).

### 4.1.5 Medicaid Beneficiaries Visits

The FQHC will provide the number of visits from Medicaid beneficiaries during the period under analysis. For verification purposes, the PR Medicaid Program requests the same information to the MCO. Note that the FQHC is the primary responsible party to provide the visits.

## 4.2 Prospective Payment System (PPS) Rate

Beginning January 1, 2001, States were mandated by BIPA to pay FQHCs using a new prospective payment system based on financial information pertaining to fiscal years 1999 and 2000. The PPS rate formula provides an average cost per visit that is later adjusted in subsequent years by the Medicare Economic Index (MEI).

The rebasing formula would be as follows:

(Total Costs FY A and FY B Minus Third Party Reforma/Vital/Other Unallowable Costs FY A and FY B) Divided By (Total Visits FY A and FY B) = Rebased PPS Rate

The allow ability of costs is presented in section 4.2.2.2.

### 4.2.1 Existing FQHCs

To determine the baseline rate for existing FQHCs prior to January 1, 2001, each Center's 1999 and 2000 allowable costs were totaled and divided by the total number of Medicaid beneficiaries' visits for the same years. The baseline calculation included all Medicaid services provided by the FQHC regardless of existing methods of reimbursement for said services. Effective January 1 of each year, the PPS rates will be increased by the percentage change in the Medicare Economic Index (MEI) for that period.

If two or more FQHCs merge, a weighted average (using total visits) of the Centers' visit rates will be used as the visit rate for the consolidated FQHC. PPS rates for services calculated on the basis of based on this cost information are FQHC wide and apply to all locations.

### 4.2.2 New FQHCs

FQHCs receiving their initial designation after January 1, 2001, will be paid on an interim basis, an average visit rate of other FQHCs located in the same or adjacent area with similar caseloads until their permanent rates are determined. The new FQHC will receive this rate for the remainder of the calendar year in which it is established and will receive annual increases thereafter consistent with the PPS payment methodology.

Within two (2) years of receiving its initial designation, the FQHC must demonstrate its actual costs using standard cost reporting methods, to establish its base visit rate. Among the information needed to support its base visit rate the FQHCs must provide the following information or any other information requested by the PPS Office as deemed appropriate corresponding to the previous two (2) fiscal years:

- Audited Financial Statements in accordance with Generally Accepted Accounting Principles ("GAAP") and supplementary information, including notes and schedules issued by a Certified Public Accountant ("CPA") with license to practice in the Commonwealth of Puerto Rico. Single Audit Report in accordance with the Office of Management and Budget ("OMB") Uniform Guidance and/or 2 CFR 200 Uniform Guidance. The CPA must provide his current peer review and/or other credentials required for the audit of federal programs, contracts, awards, and grants.
- Audited Financial Statements and supplementary information, including notes and schedules. Single Audit must be provided.
- Trial Balances
- Detail General Ledger. This document should include at least the following columns:
    - Date of the journal entry
    - Description of the transaction
    - Reference
    - Account number
    - Account description/name
    - Debit amount
    - Credit Amount

The FQHC will also provide evidence of the Medicaid beneficiaries' visits for the same two (2) years. Puerto Rico may audit or review the new FQHC's cost information to ensure the costs are reasonable and necessary.

Once the total allowable costs and visits for the base years are determined then the total allowable and reasonable costs will be divided by the total number of Medicaid beneficiaries' visits in order to determine the baseline rate for the FQHC.

### 4.2.2.1 Allowable4.2.2.1 Allowable Visits for Baseline PPS Rate

Total (on-call and regular) staff expenses must be included in reported allowable cost information. The total visits for all patients seen by staff (both regular and on-call) must be reported and used in calculating the visit rate.

To verify the number of patients and associated number of visits that physicians and other independent practitioners have seen, the clinic must maintain records that substantiate the number of visits for:

- Practitioners who receive additional compensation for their on-call time; and
- Contract practitioners during on-call time.

### 4.2.2.2 Allowable Cost Considerations for Baseline PPS Rate

To determine the PPS rates, the following are typically considered in the determination of allowable costs:

#### –Cost Information for Cost Determination

The following guidelines are the standards recommended to consider for application to the FQHC cost information used for the establishment of PPS rates, including scope of service changes to PPS rates, and should be applied in the hierarchy listed:

- 42 CFR Section 413;
- The PR Medicaid Program policies and definitions including all billing instructions (including this manual);
- OMB Uniform Guidance[11]Circular A-122 "Cost Principles for Nonprofit Organizations;", and
- Medicare Provider Reimbursement Manual (MPRM).

#### –Allowable Direct Health Services Costs

Allowable costs are costs after any cost adjustment; cost disallowances; reclassifications; or reclassifications to unallowable costs which are necessary, proper, ordinary and related to the care of medical care clients, and are not expressly declared unallowable by applicable statutes, regulations or policies. Costs are ordinary if they are of the nature and magnitude which prudent and cost-conscious management would pay consistent with the regulations and policies above.

Direct health services costs must be directly related to patient care and identified specifically with a particular cost center.

The health services provided must constitute an allowable service under the PR Medicaid Program of State Plan [Social Security Act Section 1905(a)(2)(A)] and be approved in the FQHC's approved scope of services. This generally

[11] Office of Management and Budget issued the final Guidance that supersedes requirements from OMB Circulars A-21, A-87, A-110, and A-122 (which have been placed in 2 C.F.R. Parts 220, 225, 215, and 230); Circulars A-89, A-102, and A-133; and the guidance in Circular A-50 on Single Audit Act follow-up.

includes services defined in Section 1861 (aa)(3)(A)-(C); (gg) and (vv) of the Social Security Act which lists FQHC-required core services for:

- The ongoing, continuous or repetitive management of a patient's health care, inclusive of services and supplies; and
- The overall coordination of all services provided to the patient.

All services must be provided by PR Medicaid Program of State Plan' authorized providers. Services and supplies "incident to" professional services of health care practitioners are those commonly furnished in connection with these professional services, generally furnished in a physician or dentist's office and ordinarily rendered without charge or included in the practice bill, such as ordinary medications and other services and supplies used in patient primary care services. "Incident to" services must be provided by a clinic employee and must be provided under the direct, personal supervision of the health care practitioner, meaning that the health care practitioner must be physically present in the building and immediately available for consultation.[12]

FQHC core services include those professional services provided in the office, other medical facility, the patient's place of residence (including nursing homes) or elsewhere, but not the institutional costs of the hospital, nursing facility, etc. Core services are covered for Medicaid beneficiaries.

The following are covered services to the extent they are covered in PR Medicaid Program of State Plan and any approved Medicaid waivers, and costs for these services provided to PR Medicaid Program beneficiaries are allowable in the cost information:

- Preventive services
- FQHC core services
  - –Physician services, including costs for contracted physician services, Contracted physicians must be identified in the FQHC's Core Provider Agreement. The contracted physician must be a preferred provider and receive an identification number from the Provider Enrollment Section at HRSA.
  - –Mid-Level Practitioner services –, including costs for contracted mid-level practitioner services.
- Dentist services
- Clinical Psychologist services
- Psychiatrist services
- Clinical Social Worker services (CSWs)
- Emergency Room Services Dentist services

[12] "Incident to" is defined at 1861 (aa)(3)(A)-(C); (gg) and (vv) of the Social Security Act).

- Clinical Social Worker services (CSWs)
- Other Ambulatory Services
  - Blood draws;
  - Laboratory tests;
  - X-rays;
  - Pharmacy (Note: Pharmacy service costs that are not "referred services" or subcontracted services and are reimbursable under the PR Medicaid Program of State Plan would be included under direct costs in the cost information including 340B costs directly incurred by the clinics. All pharmacy costs should be included in the medical cost center of the cost information);
  - Optical services;
  - Dental *Note: all policy references in this Section to medical services include dental services as covered under the Medicaid State Plan.*
  - Other mental health practitioners eligible under the mental health benefit.
- Diabetes Self-Management Training Services and Medical Nutrition Therapy services
- EPSDT.
- Paper medical record costs including pharmacy and dental records. Because there is new funding available for electronic health records (EHR) under the American Recovery and Reinvestment Act (ARRA), all funds, credits and grants to pay for EHR should be reflected in the cost information and offset against appropriate costs. Only the unreimbursed portion of EHR is allowable. EMH costs that are not capitalized, such as monthly service costs, *a*re allowable in Allowable Direct Service Costs. Hardware, software and other EHR costs meeting MPRM CMS Publication 15-1 capitalization requirements must be capitalized and depreciated (net of credits, grants, etc.); the allowable depreciation may be included in Allowable Direct Service Costs. FQHCs will place the depreciation of EHR into Allowable Direct Service Costs to result in a similar treatment of EHR to paper records and medical equipment that allows for the non-payment of costs of EHR unrelated to PR Medicaid Program.

**Documentation** – Documentation must be available for review, including support for all allowable costs and related services. Until a chart or Medicaid identification number is established for a newborn, when a practitioner sees the baby, the visit must be clearly documented in the mother's record.

### ***UnAllowAble Direct HeAlth Services Costs***

The PR Medicaid Program will only pay a visit rate for services provided to an eligible Medicaid/CHIP beneficiary. Visits for any individual other than an eligible Medicaid/CHIP beneficiary are not reimbursed including any out-of-territory

Medicaid/CHIP, Medicare, private pay or uninsured services. Costs are not allowable if not documented, necessary, ordinary, and related to the delivery of care and services to eligible Medicaid/CHIP patients. Costs for services provided to Medicaid/CHIP beneficiaries that are offered by the FQHC, but not included in the Medicaid/CHIP State Plan or delivered consistent with the PR Medicaid Program State Plan and any approved waivers are unallowable, including but not limited to:

- Women, Infants and Children (WIC) Program – reimbursements for nutritional evaluation and/or nutritional counseling in the WIC program only apply when the service is part of the EPSDT program. Costs for nutritional assessment and/or nutritional counseling are allowed under the following circumstances only:
- Staff education, except for training and staff development, required to enhance job performance for employees of the clinic. Student loan reimbursements are considered to be unallowable education expenses.
- Beneficiary outreach and outreach to potential clients, except for the following type of activities: informing the target population of available services, such as telephone yellow pages, brochures, and handouts. Excluded outreach costs include but are not limited to advertising, participation in health fairs, and other activities designed to increase the number of individuals served or the number of services received by individuals accessing services.
- Assisting other health care professionals in the provision of off-site training, such as dental screening, blood pressure checks, etc.
- Public relations dedicated to maintaining the image or maintaining or promoting understanding and favorable relations with any segment of the public. For example, costs of meetings, conventions, convocations, or other events related to other activities of the non-profit organization, including: costs of displays, demonstrations, and exhibits; costs of meeting rooms, hospitality suites, and other special facilities used in conjunction with shows and other special events; and salaries and wages of employees engaged in setting up and displaying exhibits, making demonstrations, and providing briefings; costs of promotional items and memorabilia, including models, gifts, and souvenirs; and costs of advertising and public relations designed solely to promote the non-profit organization.
- Community services, such as health presentations to community groups, schools, etc.
- Environmental activities designed to protect the public from health hazards such as toxic substances, contaminated drinking water and shellfish.
- Research.
- Costs associated with the use of temporary health care personnel.
- Costs for subcontracted services (referred services) other than subcontracted physicians and independent practitioners who may bill for separate visits. For example: costs for laboratory, x-ray, and pharmacy

subcontracts that the clinic has for performance of support services. The laboratory, x-ray facility or pharmacy bills directly to and is reimbursed directly from MCO or the PR Medicaid Program.

- Institutional services such as hospital care, skilled nursing care, home health services, rehabilitative services, inpatient or outpatient mental health services that are provided on an inpatient or outpatient basis, excluding the professional component (which may be included in the cost information).
- Services that are not directly provided by the clinic.
- Services by alternative providers not covered in the PR Medicaid Program (PPS Office) State Plan (i.e., acupuncturists).

### *OverheAD Costs*[13]

Overhead costs are those that have been incurred for common or joint objectives and cannot be readily identified with a particular final cost objective. Allocated overhead costs must be clearly segregated from other functions and identified as a benefit to a direct service. Costs that can be included in the overhead cost center consistent with the regulations and policies are:

- Space costs, which are defined as building depreciation, mortgage interest and facility lease costs. The FQHC is required to have a reasonable floor space allocation plan that adequately documents facility usage. At least 25 percent of the facility must be used for a direct cost function (i.e., medical). Depreciation in the Medicaid Cost Report must be consistent with that claimed on the clinic's Medicare cost report. Guidelines may be found in the Medicare Provider Reimbursement Manual CMS publication 15-1. The FQHC will utilize its Medicare depreciation schedule for all items and maintain documentation of that schedule for Medicaid auditors.
- Financing costs (including interest) to acquire, construct, or replace capital assets, subject to the conditions of the OMB Uniform Guidance section 200.
- Billing department costs that are separate and distinct functions of the FQHC for the purpose of billing for medical/behavioral/dental care only. Staff must be solely dedicated to medical billing and duties must be assigned in advance.
- Medical receptionist, program registration, and intake costs.
- Supplies, telephones, Electronic Practice Management, and copy machines.

[13] ~~Direct cost of minor amounts may b~~e treated as indirect costs as described below. Because of the diverse characteristics and accounting practices of non-profit organizations, it is not possible to specify the types of direct costs which may be classified as indirect costs in all situations. However, typical examples of direct costs that may be treated as indirect costs for many non-profit organizations may include depreciation or use allowances on buildings and equipment, the costs of operating and maintaining facilities, and general administration and general expenses, such as the salaries and expenses of executive officers, personnel administration, and accounting.

- Dues for personnel to professional organizations that are directly related to the individual's scope of practice. **Limited to one professional organization per professional**.
- Utilization and referral management costs.
- Credentialing.
- Clinical management costs.
- Dues to industry organizations. Limited to those dues that are not grant funded or used by organizations for lobbying activities. **Limited to one industry organization per clinic**. Note: this includes memberships in business, technical, and professional organizations.
- Costs associated with employees who verify Medicaid eligibility.
- Data processing expenses (not including computers, software or databases not used solely for patient care or clinic administration purposes).
- Finance and Audit Department costs.
- Human Resources Department costs.
- Administration and disaster recovery and preparedness costs.
- Facility and phone costs for out-stationed financial workers.
- Per Circular OMB A-122OMB Uniform Guidance, maintenance costs incurred for necessary maintenance, repair or upkeep of buildings and equipment (including Federal property unless otherwise provided for), which neither add to the permanent value of the property nor appreciably prolong its intended life, but life but keep it in an efficient operating condition. Costs incurred for improvements which add to the permanent value of the buildings and equipment or appreciably prolong their intended life shall be treated as capital expenditures.
- Per Circular OMB A-122OMB Uniform Guidance, security costs and necessary and reasonable expenses incurred for routine and homeland security to protect facilities, personnel, and work products, are allowable. Such costs include, but are not limited to: wages and uniforms of personnel engaged in security activities, equipment, barriers, contractual security services, consultants, etc.

### *UnAllowAble OverheAd Costs And Other Expenses*

Unallowable costs, as noted in Federal regulations at 42 CFR 413, should be removed from Medicaid cost information. Other unallowable overhead costs and expenses consistent with the regulations and policies stated above include but are not limited to the following:

- **Costs not related to patient care.**

- **Indirect costs allocated to unallowable direct health service costs** are also unallowable per Circular OMB A-122OMB Uniform Guidance. The costs of certain activities are unallowable as charges to Federal awards (for example, fundraising costs). However, even though these costs are unallowable for purposes of computing charges to Federal awards, a share must be allocated to the organization's indirect costs if they represent activities which (1) include the salaries of personnel, (2) occupy space, and (3) benefit from the organization's indirect costs.
- **Interest** – costs incurred for interest on borrowed capital, temporary use of endowment funds, or the use of the non-Federal entity's own funds are unallowable as per Uniform Guidance section 200.449.
- **Entertainment** (e.g., office parties/social functions, costs for flowers, cards for illness and/or death, retirement gifts and/or parties/social functions, meals and lodging) are unallowable. This includes amusement, diversion, and social activities and any costs directly associated with such costs (such as tickets to shows or sports events, meals, lodging, rentals, transportation, and gratuities). These costs are unallowable and cannot be included as a part of employee benefits.
- **Board of Director Fees** – Travel expenses related to mileage, meal and lodging for conferences; and registration fees for meetings not related to operating the clinic (e.g., clinic-sponsored annual meetings, retreats, and seminars). Allowable travel would include attending a standard Board of Directors' meeting. The reimbursement level for allowed travel is based on the lesser of actual costs or Puerto Rico travel regulations.
- **Federal, territory, and other income taxes and excise taxes.**
- **Medical Licenses** – Costs of medical personnel professional licenses.
- **Donations, services, goods and space** except those allowed in Circular A-122OMB Uniform Guidance and the MPRM.
- **Fines and penalties.**
- **Bad debts,** including losses (whether actual or estimated), arising from uncollectable accounts and other claims, related collection costs, and related legal costs
- **Advertising**, except for the recruitment of personnel, procurement of goods and services, and disposal of medical equipment and supplies.
- **Contributions to a contingency reserve** or any similar provision made for events, the occurrence of which cannot be foretold with certainty as to time, intensity, or with an assurance of their happening. The term "contingency reserve" excludes self-insurance reserves, pension funds, and reserves for normal severance pay.
- **Over-funding contributions to self-insurance funds** that do not represent payments based on current liabilities. Self-insurance is a means by which a provider independently or as part of a group

undertakes the risk of protecting itself against anticipated liabilities by providing funds in an amount equal to anticipated liabilities, rather than by purchasing insurance coverage. Accrued liabilities related to contributions to a self-insurance program that are systematically made to a funding agency and that cover malpractice and comprehensive general liability, unemployment compensation, workers' compensation insurance losses or employee health benefits, must be liquidated within 75 days after the close of the cost reporting period.

- **Legal, accounting, and professional services** incurred in connection with hearings and re-hearings, arbitrations, or judicial proceedings against the Department. This is in addition to the unallowable costs listed for similar costs in connection with any criminal, civil or administrative proceeding in A-122OMB Uniform Guidance.
- **Fund raising costs.**
- **Amortization of goodwill.**
- **Membership dues for public relations**, except for those allowed as a direct health care covered cost or overhead cost. For example, costs of membership in any civic or community organization, country club or social or dining club or organization are unallowable.
- **Political contributions and lobbying expenses** or other prohibited activity under A-122OMB Circular Guidance.
- **Costs allocable to the use of a vehicle or other company equipment for personal use**, as well as any personal expenses not directly related to the provision of covered services; mileage expense exceeding the current reimbursement rate set by the federal government for its employee travel; or out of territory travel expenses not related to the provision of covered services, except out-of-territory travel expenses for training courses that increase the quality of medical care or the operating efficiency of the FQHC.
- **Costs applicable to services, facilities and supplies** furnished by a related organization in excess of the lower of cost to the related organization or the price of comparable service. Circular A-122 addresses consulting directly related to services rendered.
- **Vending machine expenses.**
- **Charitable contributions.**
- **Restricted grants.** Grants for specific purposes are to be offset against allowable expenses including costs paid for by specific grants or contributions (e.g. supplies, salaries, equipment, etc.) This does not include grants received under Section 330 of the Public Health Services Act. When a provider receives a payment from any source prior to the submission of a claim, the amount of the payment must be shown as a credit on the claim in the appropriate field.

- **Unallowable costs** noted in 42 CFR 413, Circular A-122 and the Medicare Reimbursement Manual (MPRM).

### 4.2.3 Adjustment of Rate

PPS Rates are adjusted as of every January 1st utilizing the published Medicare Economic Index (MEI) as prescribed in Section 1902(bb)(3)(A) of the Social Security Act.

## 4.3 Income related to Medicaid Beneficiaries

The wraparound payment to FQHCs is one of supplemental nature to make up for the difference between the income the FQHC is receiving for Medicaid beneficiaries visits and for what the FQHC is entitled to via the detailed PPS methodology. Therefore, any amount paid by the MCO or any other entity, related to Medicaid beneficiaries, has to be deducted from the wraparound computation. These payments could be made in the form of net capitation payments, fee for services and other concepts (such as Emergency Room 3rd Shift Subsidy provided by the Department of Health of Puerto Rico).

### 4.3.1 Net Capitation Payments

The managed care health plan provides services to Medicaid beneficiaries through contracted MCOs and their provider network, including FQHCs. The MCO administers its network of providers and compensates them through a capitation payment arrangement based on a predetermined rate per service. The capitation payment amount to be used in the wraparound calculation should be net of payments to third parties. [14]

The monthly capitation payments made to the FQHC can be found in the capitation reports provided by the MCO. The total capitation payments received by the FQHC must be adjusted by the percentage of the total population of the FQHC that corresponds to Medicaid beneficiaries. The sum of all payments made in the quarter adjusted by the Medicaid population breakdown percentage must be included as part of the income component of the wraparound formula.

### 4.3.2 Fee for Services

The MCO assigns the FQHC a capitation payment based on the Center's monthly membership. This payment includes all outpatient primary and preventive services that the FQHC must provide. When the FQHC cannot

[14] We must note that the MCO establishes a monthly payment per beneficiary that covers all services included in the contract between the FQHC and the MCO. If any of the services that must be provided by the FQHC is provided by a third party the MCO pays for this service and discounts it from the capitation payment made to the FQHC. Therefore, the FQHC receives a capitation payment net of all payments to third parties.

provide one of these required services, and refers the Medicaid beneficiaries to a third party, the MCO discounts this payment from the monthly capitation paid to the FQHC. In some of these cases, the patients are referred to other providers that the FQHC administers itself. For these services the MCO pays the FQHC as if it were a third party. These payments are known as a fee for services (FFS) paid to the FQHC as a provider (or third party). The sum of all payments made in the quarter adjusted by the Medicaid visits breakdown percentage and they must be included as part of the income component in the wraparound formula.

### 4.3.3 Other Payments Received

The FQHC can receive other payments related to all the patients served. If the Department of Health of Puerto Rico or another governmental entity makes this payment, but are not consider in the wraparound payment computation, the income of the FQHC will be underestimated, which will overstate the wraparound payment. Therefore, other payments such as Emergency Room 3rd Shift Subsidy provided by the Department of Health of Puerto Rico needs to be included in the formula.

### 4.3.4 Allocation for Medicaid beneficiaries

The payments received by the FQHC and mentioned above, cover services to all patients treated by the Center and not just Medicaid beneficiaries. In order to determine the portion of the payments received corresponding to Medicaid beneficiaries, the monthly membership of the FQHC will be established. The MCO provides the PR Medicaid Program with a report that includes the total members per category assigned to the FQHC each of the months corresponding to the quarter under analysis. The different categories of patients assigned to the FQHCs are:

- Federal Medicaid
- Chips
- State Medicaid

The total Federal Medicaid and Chips patients divided by the total members assigned to the FQHC will represent the percentage of income received by the FQHC related to Medicaid beneficiaries.

## 5. Timeline Schedule for documentation

All necessary data will be collected by the PPS Office and ASES. The table below shows the timeline to submit the necessary information in order for the PR Medicaid Program, PPS Office to timely disburse any wraparound payment, when applicable.

| Document Needed | Responsible Entity | Purpose | Due Date |
|---|---|---|---|
| Medicaid Beneficiaries assigned to the FQHC (Population) | From MCO to ASES to Medicaid | Determine population Multiplier | 15 calendar days following the end of each calendar quarter |
| Visits for the Period (#) | From MCO to ASES to Medicaid FQHC | Determine:<br>(1) Number of visits from qualifying beneficiaries during the quarter<br>(2) Costs of services<br>(3) Visits Multiplier | 15 calendar days following the end of each calendar quarter Revised information should be provided 60 calendar days following the end of each calendar quarter |
| Visits for the Period | From FQHC to Medicaid | For validation purposes | 15 calendar days following the end of each calendar quarter |
| Net Capitation Payment for the Period | From MCO to ASES to Medicaid MCO | Determine income for the quarter | 15 calendar days following the end of each calendar quarter |
| Fee for Services received by the FQHC as a Provider | From MCO to ASES to Medicaid MCO | Determine income for the quarter | 15 calendar days following the end of each calendar quarter |
| Other Payments received by the Center FQHC | Department of Health of Puerto Rico and/or any other responsible entity | Determine income for the quarter | 15 calendar days following the end of each calendar quarter |

All information should be FQHCs shall submit their reconciliation request and supporting information within 15 calendar days following the end of each calendar quarter. The PR Medicaid Program will review the information and request any clarification within thirty (30) days of receipt of the information. The wraparound payment formula and any amount owed shall be disbursed within thirty (30) days of receiving all information and explanation of any all doubts (no later than sixty (60) days from receiving the information for the first time).

The timely payment of the wraparound payment is subject to the FQHC cooperation providing the correct information on the period required.

## 6. Record Keeping

The FQHC must maintain all clinical and fiscal records in accordance with written policies and procedures. The records must distinguish one type of service from another. A designated professional staff must be responsible for maintaining the records to ensure that they are complete, accurate, readily accessible, and organized.

The FQHC is responsible for:

- Maintaining adequate financial and statistical records in the form that contains the data required by the PPS Office.
- Making the records available for verification and audit by the PPS Office or its contracted auditing agent, and
- Maintaining financial data on an accrual basis, unless it is part of a governmental institution that uses a cash basis accounting.

The FQHC must maintain the confidentiality of records, provide safeguards against loss, destruction or unauthorized use, govern removal of records from the Center and the conditions for release of information. The recipient's written consent must be obtained before the release of information not authorized by law.

Reimbursement may be suspended if the FQHC does not maintain records that provide an adequate basis to support payments. The suspension will continue until the FQHC demonstrates to the satisfaction of the PPS Offices it does, and will continue to, maintain adequate records.

Records must be retained for at least seven (7) years from the date of service or longer as required by Puerto Rico's statute.

## 7. Changes in Service

Puerto Rico will adjust the PPS rate for any changes in services that qualify as scope of service changes. A scope of service change is defined as a change in the type, intensity, duration and/or amount of services provided by the FQHC. Changes in costs alone shall not be considered changes in the scope of services.

The FQHC is responsible for notifying the PR Medicaid Program, in writing, of any change in the scope. When such an evaluation of the PPS rate is necessary due to a change in the scope of services, the following procedure will be followed:

- The FQHC will provide to the PR Medicaid Program sufficient and necessary documentation for any approved scope of service change, including:
    a. A full description of the change and the date the new or deleted services are effective.
    b. Evidence that the new service is under contract with the MCO.
    c. Projected cost for the new/deleted service with related projected impact in the number of visits
    d. Anticipated impact on the overall FQHC costs and visits (e.g. facility costs, administrative allocations, etc.)
    e. Any other information the PR Medicaid Program deems appropriate to perform an accurate estimate of the impact of the change in scope
- Upon receipt of all required information, the PR Medicaid Program will establish an interim rate for any approved scope of service change
- The interim rate will be effective on either the date the new/deleted service began or sixty (60) days prior to the date the PR Medicaid Program received written notice of the scope of service change, whichever is later.
- Within eighteen (18) months of approval of the effective date, the Center must submit twelve (12) months of cost and visit information reflecting actual costs of the new/deleted service and the impact to overall FQHC costs and total visits.
- The PR Medicaid Program will review the information to determine if the costs are reasonable and necessary, and adjust the interim rate by the allowable cost-per-visit to establish a final visit rate. The final new visit rate will be implemented retroactively back to the effective date.

This procedure may be triggered by the FQHC or the PR Medicaid Program through a formal letter send to the other party notifying the scope of change.

## Categorizations of Scope changes

| Type | Categorization | Example |
|---|---|---|
| Type A | Scope change would incorporate the majority of costs (e.g., is primarily characterized as uncapped administration). | New expenses due to paper medical records and depreciation associated with Electronic Health Records, medical receptionists and telephones related to practice management |
| Type B | Scope change that some but not all costs would be incorporated (e.g., is primarily characterized as capped administration), | Billing department expenses; data processing expenses; finance and audit department costs; human resource costs; maintenance; space costs devoted to administration and not to medical care |
| Type C | Scope change that would increase the number of encounters and could affect the average costs (e.g., additional volume of substantially different services) | Adding vision services to the clinic when none had previously been provided. Note: this could result in a decrease in PPS rate if the service added has less average cost than the historic services provided. |
| Type D | Scope change that primarily would increase the number of encounters without affecting the average costs (e.g., additional volume of similar or existing services). In this case very little if any of the additional costs would be reflected in an increased PPS rate. | Adding more capacity for primary care providers such as mid-level practitioners or a new site providing primary care |
| Type E | whether the request results in a scope change that is primarily non-allowable costs | Beneficiary outreach and non-covered services such as acupuncturists |

## 8. Other Changes

FQHCs are required to notify the PR Medicaid Program, in writing, within seven (7) working days of any of the following changes:

- Loss of FQHC status,
- Opening(s) and/or closing(s) of any satellite center(s),
- Change in ownership

When there is a change in ownership, PR Medicaid Program must be notified within thirty (30) calendar days of the date of the FQHC ownership change.

## 9. Appeals

It is the policy of PPS Office at PR Medicaid Program to negotiate all conflicts in a professional and organized manner. All FQHCs will have up to sixty (60) days after receiving notice of its wraparound payment to submit to the PPS Office any objections as to the amount. The FQHC must provide a detailed claim, including copy of all the evidence that supports the FQHC allegation.

Once the PPS office receives the claim it will have an additional thirty (30) days to review the FQHC's claim and communicate its decision to the FQHC. If the PPS office discovers an error and determines that an additional payment is due, PR Medicaid Program will have fifteen (15) days following such determination to pay the FQHC the amount due. If the PPS Office concludes that the wraparound calculation is correct, and no additional payment is due, a notification will be send to the FQHC on that regard.

Any unresolved conflict or controversy between any FQHC and PR Medicaid Program or PPS Office will be handled in first instance according to the administrative guideline number 85 of the Puerto Rico Department of Health **"Reglamento del Secretario de Salud para Regular los Procedimientos Adjudicativos en el Departamento de Salud y sus Dependencias"** and by the Law number 38 from June 30, 2017, **"Ley de Procedimientos Administrativos Uniforme del Gobierno de Puerto Rico (LPAU)".**

## 10. Recoupment of Overpayment

Each FQHC is individually liable for any payments received and must ensure that it receives payments only for eligible visits and services. FQHCs supporting documentation for wraparound payments are subject to audit by the PR Medicaid Program of PPS Office, and FQHCs are responsible to repay any overpayments complete by mistake, misleading, misinformation, fraud or any other underserved payment made on the wrong belief of accurate information. Upon petition, complete and legible documentation must be made available to PR Medicaid Program of PPS Office on the time frame requested.

## 11. Validity Clause

If any provision of this Ruling is declared invalid or unconstitutional by a competent court, such determination will not affect the validity of the remaining provisions thereof.

## 12. Ruling Authority

This Ruling repeals any previously regulation on this matter made by PR Medicaid Program. This Regulation will enter into force immediately after approval by the PR Medicaid Program Executive Director and/or by the Secretary of the Department of Health of Puerto Rico.

**PR Medicaid Program Director**

**Secretary of the Department of Health of PR**

## 13. Contact Information

All correspondence shall be directed to:

**Attn: PPS Officer**

PR Medicaid Program (PPS Office)

PR Department of Health

PO Box 70184

San Juan, PR 00936-8184

Telephone: 787-765-2929 x 6700

**Exhibit C**

**Notice of Look-Alike Designation**

| | |
|---|---|
| **1.Date Issued:** 7/31/2017 | **U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**<br>**HEALTH RESOURCES AND SERVICES ADMINISTRATION**<br>HRSA<br>**NOTICE OF LOOK-ALIKE DESIGNATION**<br>**Federally Qualified Health Center Look-Alike**<br>Section 1861(aa)(4)(B) of the Social Security Act (42 U.S.C. 1395x),<br>Section 1905(l)(2)(B)(iii) of the Social Security Act (42 U.S.C. 1396d), as amended |
| **2.Supersedes Designation Notice Dated:**<br>N/A | |
| **3. Designation Notice NO.**<br>1 LALCS31124-01-00 | |
| **4. LAL Number:**<br>LALCS31124 | |
| **5. Former LAL Number:**<br>N/A | |
| **6. Designation Period:**<br>**From:** 8/1/2017 **Through:** 7/31/2020 | **7. Annual Certification Period:** :<br>**From:** 8/1/2017 **Through:** 7/31/2018 |
| **8.Title of Project (or Program):** | |
| **9. Entity Name and Address:**<br>Community Health Foundation Of Puerto Rico Inc.<br>Marginal Santa Cruz C-17 URB Santa Cruz<br>BAYAMON, PR 00961 | **10. Project Director:**<br>Vania Medina<br>Community Health Foundation Of Puerto Rico Inc.<br>Marginal Santa Cruz C-17 URB Santa Cruz<br>BAYAMON, PR 00961 |
| **11. THIS ACTION IS BASED ON THE INFORMATION SUBMITTED TO, AND AS APPROVED BY HRSA, AS REQUIRED UNDER 42 CFR PART 405.2434 FOR THE ABOVE TITLED ENTITY AND IS SUBJECT TO THE TERMS AND CONDITIONS INCORPORATED EITHER DIRECTLY OR BY REFERENCE IN THE FOLLOWING:**<br>a. The authorizing program legislation cited above;<br>b. The program regulation cited above; and<br>c. HRSA look-alike policies and procedures.<br>In the event there are conflicting or otherwise inconsistent policies applicable to the program, the above order of precedence shall prevail. | |
| 12.**REMARKS:** (Other Terms and Conditions Attached **[X] Yes [] No**) | |
| ***Electronically signed by Tonya Bowers, on behalf of the Deputy Associate Administrator on: 7/31/2017 4:58:41 PM*** | |

## HRSA Electronic Handbooks (EHBs) Registration Requirements

The project director listed on this Notice of Look Alike Designation (NLD) and the authorizing official of the Health Center Program look-alike (LAL) organization are required to register (if not already registered) within HRSA's Electronic Handbooks (EHBs). Registration within HRSA EHBs is required only once for each user for each organization they represent. To complete the registration quickly and efficiently we recommend that you note the LAL number in Section 4 of this NLD. After you have completed the initial registration steps (i.e., created an individual account and associated it with the correct designee organization record), be sure to add this designation to your portfolio. This registration in HRSA EHBs is required for submission of noncompeting continuation applications. In addition, you can also use HRSA EHBs to perform other activities such as updating addresses, updating email addresses and submitting certain deliverables electronically. Visit https://grants.hrsa.gov/2010/WebEPSExternal/login.aspx to use the system. Additional help is available online and/or from the HRSA Call Center at 877-Go4-HRSA/877-464-4772 or 301-998-7373.

## Terms and Conditions

**Failure to comply with the special remarks and condition(s) may result in a removal of look-alike designation.**

### Program Specific Term(s)

1. Pursuant to existing law, and consistent with Executive Order 13535 (75 FR 15599), health centers are prohibited from using Federal funds to provide abortion services (except in cases of rape or incest, or when the life of the woman would be endangered).

2. Health Center Program look-alikes are required to submit an Annual Certification application within the designation period and a Renewal of Designation application prior to the end of the designation period. Failure to submit the Renewal of Designation or Annual Certification application in accordance with the specific instructions from the Program Office may result in termination of the look-alike designation and all corresponding benefits.

3. Look-alikes are subject to the strictures of the Medicare and Medicaid anti-kickback statute (42 U.S.C. 1320a - 7b(b) and should be cognizant of the risk of criminal and administrative liability under this statute, specifically under 42 U.S.C. 1320 7b(b), Illegal remunerations, which states, in part, that whoever knowingly and willfully: (A) Solicits or receives (or offers or pays) any remuneration (including kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind, in return for referring (or to induce such person to refer) an individual to a person for the furnishing or arranging for the furnishing of any item or service, OR (B) In return for purchasing, leasing, ordering, or recommending purchasing, leasing, or ordering, or to purchase, lease, or order, any goods, facility, services, or item for which payment may be made in whole or in part under subchapter XIII of this chapter or a State health care program, shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

4. This Notice Look-alike Designation (NLD) reflects approval of the following service delivery site(s) in the look-alike scope of project:

Community Health Foundation of Puerto Rico, Inc.
Marginal Santa Cruz C-17
Urbanizacion Santa Cruz
Bayamon, PR 00961

5. In accordance with section 330(q) of the Public Health Service Act, all Health Center Program look-alikes are required to provide for an independent annual financial audit of any books, accounts, financial records, files, and other papers and property which relate to funds allocated to the Health Center Program look-alike project. For purposes of assuring accurate, current, and complete disclosure of the disposition or use of the funds received, each such audit shall be conducted in accordance with generally accepted accounting principles. All Health Center Program look-alikes must submit their most recent annual financial audit as part of their Renewal of Designation application. The audit must include the Auditor's report (including the auditor opinion, financial statements, auditor's notes and required communication from the auditor). In addition, the audit must include any management letters issued by the auditor.

6. Consistent with Departmental guidance, Health Center Program look-alikes that purchase, are reimbursed or provide reimbursement to other entities for outpatient prescription drugs are expected to secure the best prices available for such products and to maximize results for the grantee organization and its patients. Eligible health care organizations/covered entities that enroll in the 340B Program must comply with all 340B Program requirements and will be subject to audit regarding 340B Program compliance. 340B Program requirements, including eligibility, can be found at www.hrsa.gov/opa.

7. Health centers are reminded that separate Medicare enrollment applications must be submitted for each "permanent unit" at which they provide services. This includes units considered both "permanent sites" and "seasonal sites" under their HRSA scope of project. (See: http://www.bphc.hrsa.gov/about/requirements/scope for more information). Therefore, for Medicare purposes, a single health center organization may consist of two or more FQHCs, each of which must be separately enrolled in Medicare and submit bills using its unique Medicare Billing Number. The Medicare enrollment application is located at http://www.cms.hhs.gov/cmsforms/downloads/cms855a.pdf. To identify the address where the package should be mailed, please refer to http://www.cms.hhs.gov/MedicareProviderSupEnroll/downloads/contact_list.pdf. The appropriate Medicare contractor is listed next to "Fiscal Intermediary." Successful enrollment in Medicare as an FQHC does not automatically qualify a health center for payment as an FQHC under its State Medicaid program. Health centers should contact their State Medicaid office directly to determine the process and timeline for becoming eligible for payment as an FQHC under Medicaid.

8. The DHHS Inspector General maintains a toll-free hotline for receiving information concerning fraud, waste, or abuse involving Federal resources. Such reports are kept confidential and callers may decline to give their names if they choose to remain anonymous. Contact: Office of Inspector General, Department of Health and Human Services, Attention: HOTLINE, 330 Independence Avenue Southwest, Cohen Building, Room 5140, Washington, D. C. 20201, Email: Htips@os.dhhs.gov or Telephone: 1-800-447-8477 (1-800-HHS-TIPS).

9. A health center's scope of project includes the approved service sites, services, providers, service area(s) and target population which are supported (wholly or in part) under the total budget approved for the health center. In addition, scope of project serves as the basis for eligibility for programs associated with the Health Center Program such as Medicare and Medicaid Federally Qualified Health Center (FQHC) reimbursements and 340B Drug Pricing. Proper documentation and maintenance of an accurate scope of project is critical in the oversight and management of programs funded or designated under section 330 of the PHS Act. Health centers are responsible for maintaining the accuracy of their Health Center Program scope of project, including updating or requesting prior approval for significant changes to the scope of project when applicable. Refer to the Scope of Project policy documents and resources available at: http://www.bphc.hrsa.gov/programrequirements/scope.html for details pertaining to changes to services, providers, sites, service area zip codes, and target population(s).

10. In any Health Center Program-related activity in which family, marital, or household considerations are, by statute or regulation, relevant for purposes of determining beneficiary eligibility or participation, health centers must treat same-sex spouses, marriages, and households on the same terms as opposite-sex spouses, marriages, and households, respectively. By "same-sex spouses," HHS means individuals of the same sex who have entered into marriages that are valid in the jurisdiction where performed, including any of the 50 states, the District of Columbia, or a U.S. territory or in a foreign country, regardless of whether or not the couple resides in a jurisdiction that recognizes same-sex marriage. By "same-sex marriages," HHS means marriages between two individuals validly entered into in the jurisdiction where performed, including any of the 50 states, the District of Columbia, or a U.S. territory or in a foreign country, regardless of whether or not the couple resides in a jurisdiction that recognizes same-sex marriage. By "marriage," HHS does not mean registered domestic partnerships, civil unions or similar formal relationships recognized under the law of the jurisdiction of celebration as something other than a marriage.

11. The Health Center Program project budget includes all anticipated program income sources such as fees, premiums, third party reimbursements, and payments that are generated from the delivery of services, and from “other revenue sources” such as state, local, or other federal grants or contracts, private support or income generated from fundraising or contributions. In accordance with Section 330(e)(5)(D) of the PHS Act, health centers may use their non-grant funds, either “as permitted” under section 330 or “for such other purposes … not specifically prohibited” under section 330 if such use "furthers the objectives of the project." Health centers can meet the standard of "furthering the objectives of the project" by ensuring that the uses of non-grant funds benefit the individual health center’s patient/target population.

12. Prior approval by HRSA is required for any significant change in the scope (e.g., sites or services) or nature of a Health Center Program look alike's approved project activities. Requests to change the approved scope of project, must be submitted for prior approval by HRSA via the Electronic Handbooks (EHBs) Change in Scope Module prior to implementation. See: http://www.bphc.hrsa.gov/about/requirements/scope for more information.

13. Uniform Data System (UDS) annual performance report is due in accordance with specific instructions from the Program Office. Failure to submit a complete UDS report by the specified deadline may result in the placement of conditions of designation and/or termination of the look-alike designation and all corresponding benefits.

## Contact(s)

**NLD Email Address(es):**

| First Name | Last Name | Email |
|---|---|---|
| Vania | Medina | ceo@chfpr.com |
| Jaime | Lopez | JLopez@hrsa.gov |
| | | lookalike@hrsa.gov |

Note: NLD emailed to these address(es)

**Program Contact:**

Your assigned project officer will contact you within the next 30 days. If you need assistance in the meantime, please contact:

Office of Policy and Program Development
Bureau of Primary Health Care
Health Resources and Services Administration
5600 Fishers Lane
Rockville, MD 20852

Email: lookalike@hrsa.gov
Phone: 301-594-4300

**Exhibit D**

**Letter from J. Macrae to V. Medina, dated October 2, 2019**

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Resources and Services Administration

Rockville, MD 20857

Bureau of Primary Health Care

October 2, 2019

Ms. Vania Medina
Chief Executive Officer
Community Health Foundation of Puerto Rico, Inc.
Marginal Santa Cruz C-17 URB Santa Cruz
Bayamon, PR 00961

Dear Ms. Medina:

The purpose of this letter is to notify Community Health Foundation of Puerto Rico, Inc. that its designation as a Health Center Program look-alike was terminated effective September 3, 2019.

The Health Center Program Compliance Manual, Chapter 1: Health Center Program Eligibility, indicates that health centers may not maintain look-alike designation if they are receiving a federal award under section 330 of the Public Health Service Act. Community Health Foundation of Puerto Rico, Inc. received a federal Health Center Program award on September 3, 2019, and therefore is no longer eligible for Health Center Program look-alike designation.

The Notice of Award for Grant Number H80CS33662 notifying your organization of the Health Resources and Services Administration's approval of your New Access Point application is available in your Grant Folder in the Electronic Handbooks. Please contact your Project Officer if you have any questions.

Thank you for your support of the Health Center Program and your commitment to providing primary health care services to underserved populations in your community.

Sincerely,

for James Macrae
Associate Administrator

| | | |
|---|---|---|
| **1. DATE ISSUED:** 08/29/2019 | **2. PROGRAM CFDA:** 93.224 | |
| **3. SUPERSEDES AWARD NOTICE dated:** except that any additions or restrictions previously imposed remain in effect unless specifically rescinded. | | |
| **4a. AWARD NO.:** 1 H80CS33662-01-00 | **4b. GRANT NO.:** H80CS33662 | **5. FORMER GRANT NO.:** |
| **6. PROJECT PERIOD:** **FROM:** 09/01/2019 **THROUGH:** 08/31/2021 | | |
| **7. BUDGET PERIOD:** **FROM:** 09/01/2019 **THROUGH:** 08/31/2020 | | |

U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration

NOTICE OF AWARD
AUTHORIZATION (Legislation/Regulation)
Public Health Service Act, Title III, Section 330
Public Health Service Act, Section 330, 42 U.S.C. 254b
Affordable Care Act, Section 10503
Public Health Service Act, Section 330, 42 U.S.C. 254, as amended.
Authority: Public Health Service Act, Section 330, 42 U.S.C. 254b, as amended
Public Health Service Act, Section 330, 42 U.S.C. 254b, as amended
Public Health Service Act, Section 330(e), 42 U.S.C. 254b
Section 330 of the Public Health Service Act, as amended (42 U.S.C. 254b, as amended) and Section 10503 of The Patient Protection and Affordable Care Act (P.L. 111-148)
Section 330 of the Public Health Service Act, as amended (42 U.S.C. 254b)
Public Health Service Act, Section 330, as amended (42 U.S.C. 254b)
Section 330 of the Public Health Service (PHS) Act, as amended (42 U.S.C. 254b, as amended)
Section 330 of the Public Health Service Act, as amended (42 U.S.C. 254b, as amended)
Public Health Service Act, Section 330(e), (g), (h), or (i),, as amended (42 U.S.C. 254b(e), (g), (h) and/or (i)))
The Health Center Program is authorized by Section 330(e), (g), (h) and/or (i) of the Public Health Service Act, as amended (42 U.S.C. § 254b(e), (g), (h), and/or (i)). Specifically, IBHS supplemental funding will be awarded under section 330(e

**8. TITLE OF PROJECT (OR PROGRAM):** Health Center Program

**9. GRANTEE NAME AND ADDRESS:**
Community Health Foundation Of Puerto Rico Inc.
C17 Calle Marginal
Bayamon, PR 00961-6706
**DUNS NUMBER:**
964876861
BHCMIS # 02E01268

**10. DIRECTOR:** (PROGRAM DIRECTOR/PRINCIPAL INVESTIGATOR)
Vania Medina
Community Health Foundation Of Puerto Rico Inc.
Marginal Santa Cruz C-17
Bayamon, PR 00961-6902

**11.APPROVED BUDGET:**(Excludes Direct Assistance)
[ ] Grant Funds Only
**[X]** Total project costs including grant funds and all other financial participation

| | |
|---|---|
| a . Salaries and Wages : | $764,220.00 |
| b . Fringe Benefits : | $107,240.00 |
| c . Total Personnel Costs : | $871,460.00 |
| d . Consultant Costs : | $0.00 |
| e . Equipment : | $0.00 |
| f . Supplies : | $28,700.00 |
| g . Travel : | $3,087.00 |
| h . Construction/Alteration and Renovation : | $0.00 |
| i . Other : | $871,553.00 |
| j . Consortium/Contractual Costs : | $875,200.00 |
| k . Trainee Related Expenses : | $0.00 |
| l . Trainee Stipends : | $0.00 |
| m . Trainee Tuition and Fees : | $0.00 |
| n . Trainee Travel : | $0.00 |
| o . TOTAL DIRECT COSTS : | $2,650,000.00 |
| p . INDIRECT COSTS (Rate: % of S&W/TADC) : | $0.00 |
| q . TOTAL APPROVED BUDGET : | $2,650,000.00 |
| i. Less Non-Federal Share: | $2,000,000.00 |
| ii. Federal Share: | $650,000.00 |

**12. AWARD COMPUTATION FOR FINANCIAL ASSISTANCE:**

| | |
|---|---|
| a. Authorized Financial Assistance This Period | **$650,000.00** |
| b. Less Unobligated Balance from Prior Budget Periods | |
| i. Additional Authority | $0.00 |
| ii. Offset | $0.00 |
| c. Unawarded Balance of Current Year's Funds | $0.00 |
| d. Less Cumulative Prior Awards(s) This Budget Period | $0.00 |
| e. AMOUNT OF FINANCIAL ASSISTANCE THIS ACTION | **$650,000.00** |

**13. RECOMMENDED FUTURE SUPPORT:** (Subject to the availability of funds and satisfactory progress of project)

| YEAR | TOTAL COSTS |
|---|---|
| 02 | $650,000.00 |

**14. APPROVED DIRECT ASSISTANCE BUDGET:**(In lieu of cash)

| | |
|---|---|
| a. Amount of Direct Assistance | $0.00 |
| b. Less Unawarded Balance of Current Year's Funds | $0.00 |
| c. Less Cumulative Prior Awards(s) This Budget Period | $0.00 |
| d. AMOUNT OF DIRECT ASSISTANCE THIS ACTION | **$0.00** |

NOTICE OF AWARD (Continuation Sheet)

Date Issued: 8/29/2019 11:23:30 AM
Award Number: 1 H80CS33662-01-00

**15. PROGRAM INCOME SUBJECT TO 45 CFR 75.307 SHALL BE USED IN ACCORD WITH ONE OF THE FOLLOWING ALTERNATIVES: A=Addition B=Deduction C=Cost Sharing or Matching D=Other** **[D ]**

Estimated Program Income: $1,520,000.00

**16. THIS AWARD IS BASED ON AN APPLICATION SUBMITTED TO, AND AS APPROVED BY HRSA, IS ON THE ABOVE TITLED PROJECT AND IS SUBJECT TO THE TERMS AND CONDITIONS INCORPORATED EITHER DIRECTLY OR BY REFERENCE IN THE FOLLOWING:**

a. The grant program legislation cited above. b. The grant program regulation cited above. c. This award notice including terms and conditions, if any, noted below under REMARKS. d. 45 CFR Part 75 as applicable. In the event there are conflicting or otherwise inconsistent policies applicable to the grant, the above order of precedence shall prevail. Acceptance of the grant terms and conditions is acknowledged by the grantee when funds are drawn or otherwise obtained from the grant payment system.

**REMARKS:** (Other Terms and Conditions Attached **[ X ]Yes [ ]No**)

***Electronically signed by Elvera Messina , Grants Management Officer on :*** 08/29/2019

**17. OBJ. CLASS:** 41.51 | **18. CRS-EIN:** 1660749601A1 | **19. FUTURE RECOMMENDED FUNDING:** $0.00

| FY-CAN | CFDA | DOCUMENT NO. | AMT. FIN. ASST. | AMT. DIR. ASST. | SUB PROGRAM CODE | SUB ACCOUNT CODE |
|---|---|---|---|---|---|---|
| 19 - 3981160 | 93.224 | 19H80CS33662 | $521,950.00 | $0.00 | CH | HEALTHCARECENTERS_19 |
| 19 - 398160I | 93.527 | 19H80CS33662 | $128,050.00 | $0.00 | CH | HEALTHCARECENTERS_19 |

Government of Puerto Rico

# CERTIFICATE OF GOOD STANDING

I, **MARÍA A. MARCANO DE LEÓN, Under Secretary of State** of the Government of Puerto Rico,

**CERTIFY:** That, **COMMUNITY HEALTH FOUNDATION OF PUERTO RICO INC.**, register number **60961**, a **non-profit domestic** corporation, organized under the laws of Puerto Rico on **July 23, 2010**, has complied with the filing of its Annual Reports.

**IN WITNESS WHEREOF**, the undersigned by virtue of the authority vested by law, hereby issues this certificate and affixes the Great Seal of the Government of Puerto Rico, in the City of San Juan, Puerto Rico, today, **October 8, 2019.**

**MARÍA A. MARCANO DE LEÓN**
Under Secretary of State

To validate this certificate go to: http://estado.pr.gov/

This certificate can be validated an unlimited number of times before its expiration date of 07-Oct-2020.

Certificate Validation Number: **315650-83013796**

Commonwealth of Puerto Rico
**DEPARTMENT OF STATE**
San Juan, Puerto Rico

# CERTIFICATE OF REGISTRY

I, **KENNETH D. McCLINTOCK**, Secretary of State of the Commonwealth of Puerto Rico,

**CERTIFY**: That on **July 23, 2010** at **11:35 AM** was filed a Certificate of Incorporation "**COMMUNITY HEALTH FOUNDATION OF PUERTO RICO INC.**", register number **60961** a **non profit** corporation organized under the laws of Puerto Rico.

**IN WITNESS WHEREOF**, the undersigned by virtue of the authority vested by law, hereby issues this certificate and affixes the Great Seal of the Commonwealth of Puerto Rico, in the City of San Juan today, July 23, 2010.

**KENNETH D. McCLINTOCK**
Secretary of State

*KMH/als*
*0075-E0A20897/EA20893 – $10.00*

DEPT. ESTADO
RADICACION DE DOCUMENTOS
C.U.S. CORPORACIONES

10 JUL 23 AM 11:35

Gobierno de Puerto Rico
*Government of Puerto Rico*
**DEPARTAMENTO DE ESTADO**
*Department of State*

**CERTIFICADO DE INCORPORACIÓN**
**CORPORACIÓN NO AUTORIZADA A EMITIR ACCIONES DE CAPITAL**
*CERTIFICATE OF INCORPORATION OF*
*A NON-STOCK CORPORATION*

**PRIMERO:** El nombre de la corporación es:
*FIRST: The name of the corporation is:*

**Community Health Foundation of Puerto Rico**

El nombre corporativo deberá incluir uno de los siguientes términos o abreviaturas: Incorporado *Corporación*, Corp. o Inc.
*The corporation's name must include the following terms or abbreviations: Incorporated, Corporation, Corp. or Inc.*

**SEGUNDO:** Su oficina designada en el Estado Libre Asociado de Puerto Rico estará localizada en (dirección postal y física, incluyendo calle, número y municipio):
*SECOND: Its designated office in the Commonwealth of Puerto Rico will be located at (mailing and physical address, including street, number and municipality):*

Física/Physical: **C Santa Cruz B 7**
**Bayamon, PR 00961**

Postal/*Mailing:* **C Santa Cruz B 7**
**Bayamon, PR 00961**

El Agente Residente a cargo de dicha oficina es:
*The Resident Agent in charge of said office is:*

**Ismael Toro Grajales**

**TERCERO:** Esta es una corporación sin fines de lucro cuya naturaleza o propósito son:
*THIRD: This is a not-for-profit corporation which nature or purposes are:*
**This corporation is organized exclusively for charitable, social, educational, and/or scientific purposes under the Commonwealth of Puerto Rico General Corporate Law Statutes and secc. 501 (c)(3) of the Internal Revenue Code. Please see attachment for further purposes of the not-for-profit corporation.**

**CUARTO:** La corporación no tendrá autoridad para emitir acciones de capital.
*FOURTH: The corporation shall not authority to issue any capital stock.*

Favor de marcar con una "X" el Artículo QUINTO:
*Please, mark with an "X" Article FIFTH:*

__X__ **QUINTO:** Las condiciones requeridas de los miembros habrán de figurar en los estatutos de la corporación.
*FIFTH: The conditions of membership will be stated in the by-laws.*

_____ **QUINTO:** Las condiciones requeridas de los miembros, si alguna, son:
*FIFTH: The conditions of membership, if any, are:*

**SEXTO:** El nombre y dirección postal y física (incluyendo calle, número y municipio) de cada incorporador es:
*SIXTH: The name and mailing and physical address (including street, number and municipality) of each incorporator is:*
**1) Ismael Toro; 2) Javier Fernandez; 3) Vania Medina**
**Address: C Santa Cruz B 7, Bayamon, PR 00961**

**SÉPTIMO:** Si las facultades de los incorporador(es) habrán de terminar al radicarse el certificado de incorporación, los nombres y las direcciones (incluyendo calle, número y municipio de las personas que se desempeñarán como directores hasta la primera reunión anual de los miembros o hasta que sus sucesores los reemplacen son:
*SEVENTH: If the faculties of the incorporators will end upon the filling of the certificate of incorporation, the names and addresses (including street, number and municipality) of the persons who will act as directors until the first annual meeting of the members or until their successors replace them are:*
**The above-mentioned incorporators will act as directors until the first annual meeting of the members or until their successors replace them.**

Favor de indicar con una "X" la fecha en que la corporación tendrá vigencia:
*Please indicate with an "X" the date on which the corporation will be effective:*

__X__ la fecha de radicación
*the filing date*

____ la siguiente fecha _____ (que no excederá noventa (90) días a partir de la fecha de radicación)
*the following date* *(which will not exceed ninety (90) days from filing date)*

Véase el párrafo B del Artículo 1.02 de la Ley General de Corporaciones, para otras cláusulas opcionales.
*Please see paragraph B of Article 1.02 of the General Corporation Law, for other optional clauses*

**EN TESTIMONIO DE LO CUAL,** Yo/Nosotros, _____, el/los suscribiente(s), siendo el/los incorporador(es) antes señalado(s), con el propósito de formar una corporación conforme a la Ley General de Corporaciones de Puerto Rico, juro/juramos que los datos contenidos en este certificado son ciertos, hoy día _____ del mes _____ del año _____.
*IN WITNESS WHEREOF, I /We,* **Ismael Toro**, *the undersigned being the incorporator(s) hereinbefore named, for the purpose of forming a corporation pursuant to the General Corporation Law of Puerto Rico, hereby swear that the facts herein stated in this certificate are true, this* **21th** *day of* **July**, **2010**.

Incorporador(es)
Incorporator(s)

**Correo electrónico /E-mail:** **torograjales@gmail.com; javierfndz@gmail.com; vaniamedina@ymail.com**

*Sólo corporaciones religiosas, fraternales, benéficas o educativas sin fines de lucro.
**Only for any non profit religious, fraternal, charitable or educational corporations.*

# CERTIFICATE OF INCORPORATION OF A NON-STOCK CORPORATION

## ATTACHMENT

***THIRD: This is a not-for-profit corporation which nature or purposes are:***

This corporation is organized exclusively for charitable, social, educational, and/or scientific purposes under the Commonwealth of Puerto Rico General Corporate Law Statutes and secc. 501(C)(3) of the Internal Revenue Code , including, for such purpose, the making of distributions to such organizations that qualify as exempt organizations under the Commonwealth of Puerto Rico General Corporate Law Statutes and secc. 501(C)(3) of the Internal Revenue Code.

No part of the net earnings of the corporation shall inure to the benefit of, or be distributable to its members, directors, officers, or other private persons, except that the corporation shall be authorized and empowered to pay reasonable compensation for services rendered and to make payments and distributions in furtherance of the purpose of this corporation.

No substantial part of the activities of the corporation shall be carrying on of propaganda, or otherwise attempting to influence legislation, and the corporation shall not participate in, or intervene in (including the publishing or distribution of statements) any political campaign on behalf of or in opposition to any candidate in office. Notwithstanding any other provision of these articles, the corporation shall not carry on any other activities not permitted to be carried on (1) by a corporation exempt from state income taxes under the Commonwealth of Puerto Rico General Corporate Law Statutes, or federal income tax under secc. 501(C)(3) of the Internal Revenue Code, or the corresponding section of any future state or federal tax code, or (2) by a corporation, contributions to which are deductible under 170 (c)(2) of the Internal Revenue Code, or the corresponding section of any future federal tax code.

COMMONWEALTH OF PUERTO RICO
DEPARTMENT OF STATE

# CERTIFICATE OF AMENDMENT OF THE CERTIFICATE OF INCORPORATION OF A NON-STOCK CORPORATION

Registration number: **60961**

FIRST: That in a meeting of the directive body of: **Community Health Foundation of Puerto Rico, Inc.** duly called and held, a resolution was adopted setting forth a proponed amendment to the Certificate of Incorporation of said corporation, declaring said amendment to be advisable and calling a meeting for the members of the directive body of said corporation for consideration thereof. The resolution setting forth the proponed amendment reads as follows:

RESOLVED, that the Certificate of Incorporation of this corporation be attended by changing Article THIRD so that it read as follows:

**"THIRD: This is a not-for-profit corporation which nature or purposes are:**

**A) This corporation is organized exclusively for charitable, social educational, and / or scientific purposes under the Commonwealth of Puerto Rico General Corporate Law Statutes and Section 501 (c)(3) of the Internal Revenue Code, including for such purpose, the making of distributions to such organizations that qualify as exempt organizations under said statutes.**

**B) No part of the net earnings of the corporation shall inure to the benefit of, or be distributable to its members, directors, officers, or other private persons, except that the corporation shall be authorized and empowered to pay reasonable compensation for services rendered and to make payments and distributions in furtherance of the purpose of this corporation.**

**C) To engage in the management of entities that provide health care services through a system designed to improve efficiency and reduce costs; establish an assistance program to help patients access prescription drugs with no bioequivalent in the market; to establish a medical faculty to provide health care services following the model known as "Patient Centered Medical Home"; establish the clinical-administrative structures needed for the provision of comprehensive health care services centered in the patient; promote the development of initiatives to increase access to health care services and to promote the excellence of such services; promote individual health by making available a comprehensive program of health care services coverage that meet the needs of patients**

and reduce access impediments related to the cost; promote the education of health car professionals (clinical workshops, curricula, etc.); promote meaningful use of eligible health care services providers, according to federal guidelines, the electronic medical record and the exchange of information; promote programs for the involvement and self-management of patients with respect to the improvement of their health; promote models that reward responsible and cooperative patients that comply with preventive care services and adherence to medical treatment; promote scientific research in the field of health; to promote the integration of complementary models of health and welfare services for the benefit of the community; develop initiatives that promote outpatient and home services in an innovative model focused on increasing citizen participation in the provision of health care services; negotiate all applicable contracts and provide other services for the benefit of the patients; serve as many patients in need of health care services under a model that meets their physical and psychosocial well-being; ensure that the clinical determinations in the care of patients fall on the medical faculty and that incentives, fair compensation and a work environment that promotes excellence among providers of health care services are provided; all with the purpose of accelerating the adoption of healthy practices for the population and increased collaboration with initiatives to improve health; and engage in any acts or lawful business for which not-for-profit corporations may be organized under the General Corporation Law, Law No. 164 of December 16, 2009.

MT

D) To the extent that a not-for-profit corporation can legally do it in the present or in the future, as principal or agent and by itself or through subsidiaries or in partnership with other individuals or legal entities, can perform all that is necessary, appropriate, suitable or proper for or in connection with or incidental to the attainment of any of the purposes listed above, or conceived directly or indirectly, the interests of the corporation are promoted."

E) Notwithstanding any other provision of these articles, the corporation shall not carry on any other activities not permitted to be carried on (1) by a corporation exempt from state income taxes under the Commonwealth of Puerto Rico General Corporate Law Statutes or federal income tax under Section 501 (c)(3) of the Internal Revenue Code, or the corresponding section of any future state or federal tax code, or (2) by a corporation, contributions to which are deductible under 170 (c)(2) of the Internal Revenue Code, or the corresponding section of any future federal tax code."

SECOND: That on a date no earlier that fifteen (15) days or later that Sixty (60) days from the date on which said resolution was approved, a meeting was called and held,

upon notice stating the purpose thereof, at which meeting a majority of the total number of members of the directive body voted in favor thereof.

Please indicate with an "X" the date on which the amendment will be effective:

__√__ **the filing date**
____ the following date (which will not exceed ninety (90) days from filing date)

IN WITNESS WHEREOF, I, Vania Medina Torres, the undersigned, being the authorized officer of the corporation, hereby swear that the facts herein stated in this certificate are true, this 1st. day of July, 2015.

mt

HEALTH FOUNDATION OF PUERTO RICO, INC. COMMUNITY 2010 #60961 PUERTO RICO

Vania Medina Torres MBA / HCM
Chief Executive Officer
and Authorized Officer

Entity's e-mail: ceo@chfpr.com

**COMMONWEALTH OF PUERTO RICO**
**DEPARTMENT OF STATE**

# CERTIFICATE OF AMENDMENT OF THE CERTIFICATE OF INCORPORATION OF A NON-STOCK CORPORATION

Registration number: **60961**

FIRST: That in a meeting of the directive body of: **Community Health Foundation of Puerto Rico, Inc.** duly called and held, a resolution was adopted setting forth a proponed amendment to the Certificate of Incorporation of said corporation, declaring said amendment to be advisable and calling a meeting for the members of the directive body of said corporation for consideration thereof. The resolution setting forth the proponed amendment reads as follows:

RESOLVED, that the Certificate of Incorporation of this corporation be attended by adding a new Article EIGHT that read as follows:

> **"EIGHT: In case of dissolution, the assets of the corporation shall be distributed for one or more exempt purposes."**

SECOND: That on a date no earlier that fifteen (15) days or later that Sixty (60) days from the date on which said resolution was approved, a meeting was called and held, upon notice stating the purpose thereof, at which meeting a majority of the total number of members of the directive body voted in favor thereof.

Please indicate with an "X" the date on which the amendment will be effective:

__√__ **the filing date**
___ the following date (which will not exceed ninety (90) days from filing date)

IN WITNESS WHEREOF, I, Vania Medina Torres, the undersigned, being the authorized officer of the corporation, hereby swear that the facts herein stated in this certificate are true, this 1st day of July, 2015.

COMMUNITY HEALTH FOUNDATION OF PUERTO RICO, INC.
2010
#60961
PUERTO RICO

Vania Medina Torres MBA / HCM
Chief Executive Officer
and Authorized Officer

Entity's e-mail: ceo@chfpr.com

**Exhibit E-1**

**PPS Rate Calculation (Spanish)**

# Community Health Foundation of Puerto Rico, Inc.

| | | | | | | |
|---|---|---|---|---|---|---|
| **Departamento de Salud** | | | | | | |
| **Programa MEDICAID** | | | | | | |
| **PPS Rate Determination for COMMUNITY HEALTH FOUNDATION OF PUERTO RICO, INC.** | | | | | | |
| | | | **Fiscal Year Ended December 31, 2017** | | **Fiscal Year Ended December 31, 2018** | |
| **I. Total Cost** - As per Audited Financial Statements | | | $ 1,487,658 | (A) | $ 1,896,480 | (A) |
| Less: | | | | | | |
| | Non Reimbursable Costs (Note 4) | | | | | |
| | | Employee and guest meals | - | (B) | - | (B) |
| | | Expenses of operating gift shop, snack bars, etc. | - | | - | |
| | | Personal expenses not directly related to the provision of covered services | (23,021) | | (8,938) | |
| | | Costs not related to patient care. | - | | - | |
| | | Board of Directors' fees including travel and meal costs | (4,787) | | (12,393) | |
| | | Indirect costs allocated to unallowable direct health service costs | - | | - | |
| | | Interest | (635) | | (232) | |
| | | Entertainment | (4,032) | | (5,083) | |
| | | Board of Director Fees | - | | - | |
| | | Federal, territory, and other income taxes and excise taxes. | (10,692) | | (14,672) | |
| | | Medical Licenses | - | | - | |
| | | Donations, services, goods and space | (500) | | (500) | |
| | | Fines and penalties for violations of regulations, statutes, and ordinances of all types | - | | - | |
| | | Bad debts | - | | - | |
| | | Advertising | - | | (584) | |
| | | Contributions to a contingency reserve | - | | - | |
| | | Over funding contributions to self insurance funds | (9,946) | | (11,372) | |
| | | Legal, accounting, and professional services | (27,698) | | (19,309) | |
| | | Fund raising expenses | - | | - | |
| | | Amortization of goodwill | - | | (44,015) | |
| | | Membership dues for public relations | (995) | | (6,130) | |
| | | Political contributions and lobbying expenses | - | | - | |
| | | Costs allocable to the use of a vehicle or other company equipment for personal use | - | | - | |
| | | Costs applicable to services, facilities and supplies | - | | - | |
| | | Vending machine expenses | - | | - | |
| | | Charitable contributions | - | | - | |
| | | Restricted grants | - | | - | |
| | | Unallowable costs noted in 42 CFR 413 | (1,875) | | (6,539) | |
| | | | (84,180) | | (129,765) | |
| | Total Administrative and Facility Costs Overhead non applicable to RHC/FQHC services | | | | | |
| | Total Allowable Cost of RHC/FQHC Services | | $ 1,403,478 | | $ 1,766,715 | |
| **II. Total Visits** - As per Report provided by COMMUNITY HEALTH FOUNDATION OF PUERTO RICO, INC. | | | 35,855 | (C) | 36,626 | (C) |
| | **Cost per Visits** | | $ 39.14 | | $ 48.24 | |
| | **PPS Rate** (Average 2017/2018) | | | | **$ 43.69** | |
| Note 1: | The Attachment 4.19B of the State Plan under the Social Security Act of the Commonwealth of Puerto Rico, page 1.1, establishes that the Benefit Protection and Improvement Act of 2000 (BIPA) replaced the cost based reimbursement requirement with a new effective prospective payment system (PPS) for services provided as of January 1, 2001. According to the PPS, the first year's payment is established at an average cost per visit for 1999 and 2000. The payment rates of Future years are adjusted annually according to the Medicare Economic Index (MEI). In the case of Community, the years 2017 and 2018 are being used. | | | | | |
| Note 2: | Only reasonable costs must be considered in the PPS Rate determination. Reasonable costs are defined as those costs which are allowable under Medicare Cost Principle as outlined in 42 CFR part 413. Manual Reimbursement Ruling Federally Qualified Health Centers (FQHC). | | | | | |
| Note 3: | All visits are considered only to determine the PPS Rate. | | | | | |
| Note 4: | Detailed trial balance of revenues and expenses by account numbers was provided by the Center for the proper identification of not reimbursable costs. | | | | | |
| Note 5: | Information to determine cost per visits, information provided by the Center. | | | | | |
| (A) | Audited Financial Statements for the fiscal years ended December 31, 2017 and 2018, was provided by COMMUNITY HEALTH FOUNDATION OF PUERTO RICO, INC. | | | | | |
| (B) | Audited Financial Statements for the fiscal years ended December 31, 2017 and 2018, was provided by COMMUNITY HEALTH FOUNDATION OF PUERTO RICO, INC. | | | | | |
| (C) | As per Report provided by COMMUNITY HEALTH FOUNDATION OF PUERTO RICO, INC. | | | | | |

1. Para determinar el PPS Rate:

   Se tomó el total de Costos en los Estados Financieros de los años 2017 y 2018 y se les resto los gastos no rembolsables y se dividió por el promedio de visitas de los años 2017 y 2018. El resultado fue el PPS Rate para el año 2019. Toda la información financiera utilizada para determinar el PPS Rate, tal como Estados Financieros y visitas, fue provista por el Centro Community Health.

2. El Manual "Reimbursement Ruling Federally Qualified Health Centers (FQHC) dispone lo siguiente en cuanto al cálculo de PPS Rate para un FQHC nuevo (Página 13):

   *4.2.2.*
   *New FQHCs*
   *FQHCs receiving their initial designation after January 1, 2001, will be paid on an interim basis, an average visit rate of other FQHCs located in the same or adjacent area with similar caseloads until their permanent rates are determined. The new FQHC will receive this rate for the remainder of the calendar year in which it is established and will receive annual increases thereafter consistent with the PPS payment methodology.*
   *Within two (2) years of receiving its initial designation, the FQHC must demonstrate its actual costs using standard cost reporting methods, to establish its base visit rate.*

   Con la información financiera del Centro 330 disponible, se puedo determinar un PPS Rate de $43.69 permanente. Este Centro por su localidad sería comparado con el Centro Health Pro Med (Belaval) ya que los dos se encuentran en el área metropolitana. El Centro 330 Health Pro Med tiene un PPS Rate revisado para el año 2017 de $146.72.

3. Los períodos que corresponden calcular un de wraparound, con un PPS Rate interino, sería el periodo del 1 de agosto de 2017 a 31 de diciembre de 2018. Para el periodo del año 2019, se pudo establecer un PPS Rate aplicable al Q3-2019 que se cumplen los dos años del PPS interino.

4. CHF tuvo una certificación como Look-Alike para el periodo 08/01/2017 al 07/31/2020. Para el 3 de septiembre de 2019 reciben una certificación como FQHC para el periodo de 09/01/2019 al 08/31/2021. Desconozco cada cuanto tiempo se debe renovar esta certificación. (Si tienen que renovarla ya está vencida)

5. Community Health Foundation of Puerto Rico, Inc. este presentando una reclamación por cobro de dinero desde el año 2018.

**Exhibit E-2**

**PPS Rate Calculation (Certified English Translation)**

# Community Health Foundation of Puerto Rico, Inc.

Department of Health

MEDICAID Program

**PPS Rate Determination for COMMUNITY HEALTH FOUNDATION OF PUERTO RICO, INC.**

| | Fiscal Year Ended December 31, 2017 | | Fiscal Year Ended December 31, 2018 | |
|---|---|---|---|---|
| **I. Total Cost** - As per Audited Financial Statements | $ 1,487,658 | (A) | $ 1,896,480 | (A) |
| Less: | | | | |
| Non Reimbursable Costs (Note 4) | | | | |
| Employee and guest meals | - | (B) | - | (B) |
| Expenses of operating gift shop, snack bars, etc. | - | | - | |
| Personal expenses not directly related to the provision of covered services | (23,021) | | (8,938) | |
| Costs not related to patient care. | - | | - | |
| Board of Directors' fees including travel and meal costs | (4,787) | | (12,393) | |
| Indirect costs allocated to unallowable direct health service costs | - | | - | |
| Interest | (635) | | (232) | |
| Entertainment | (4,032) | | (5,083) | |
| Board of Director Fees | - | | - | |
| Federal, territory, and other income taxes and excise taxes. | (10,692) | | (14,672) | |
| Medical Licenses | - | | - | |
| Donations, services, goods and space | (500) | | (500) | |
| Fines and penalties for violations of regulations, statutes, and ordinances of all types | - | | - | |
| Bad debts | - | | - | |
| Advertising | - | | (584) | |
| Contributions to a contingency reserve | - | | - | |
| Over funding contributions to self insurance funds | (9,946) | | (11,372) | |
| Legal, accounting, and professional services | (27,698) | | (19,309) | |
| Fund raising expenses | - | | - | |
| Amortization of goodwill | - | | (44,015) | |
| Membership dues for public relations | (995) | | (6,130) | |
| Political contributions and lobbying expenses | - | | - | |
| Costs allocable to the use of a vehicle or other company equipment for personal use | - | | - | |
| Costs applicable to services, facilities and supplies | - | | - | |
| Vending machine expenses | - | | - | |
| Charitable contributions | - | | - | |
| Restricted grants | - | | - | |
| Unallowable costs noted in 42 CFR 413 | (1,875) | | (6,539) | |
| | (84,180) | | (129,765) | |
| Total Administrative and Facility Costs Overhead non applicable to RHC/FQHC services | | | | |
| Total Allowable Cost of RHC/FQHC Services | $ 1,403,478 | | $ 1,766,715 | |
| **II. Total Visits** - As per Report provided by COMMUNITY HEALTH FOUNDATION OF PUERTO RICO, INC. | 35,855 | (C) | 36,626 | (C) |
| **Cost per Visits** | $ 39.14 | | $ 48.24 | |
| **PPS Rate** (Average 2017/2018) | | | $ 43.69 | |

Note 1: The Attachment 4.19B of the State Plan under the Social Security Act of the Commonwealth of Puerto Rico, page 1.1, establishes that the Benefit Protection and Improvement Act of 2000 (BIPA) replaced the cost based reimbursement requirement with a new effective prospective payment system (PPS) for services provided as of January 1, 2001. According to the PPS, the first year's payment is established at an average cost per visit for 1999 and 2000. The payment rates of Future years are adjusted annually according to the Medicare Economic Index (MEI). In the case of Community, the years 2017 and 2018 are being used.

Note 2: Only reasonable costs must be considered in the PPS Rate determination. Reasonable costs are defined as those costs which are allowable under Medicare Cost Principle as outlined in 42 CFR part 413. Manual Reimbursement Ruling Federally Qualified Health Centers (FQHC).

Note 3: All visits are considered only to determine the PPS Rate.

Note 4: Detailed trial balance of revenues and expenses by account numbers was provided by the Center for the proper identification of not reimbursable costs.

Note 5: Information to determine cost per visits, information provided by the Center.

(A) Audited Financial Statements for the fiscal years ended December 31, 2017 and 2018, was provided by COMMUNITY HEALTH FOUNDATION OF PUERTO RICO, INC.

(B) Audited Financial Statements for the fiscal years ended December 31, 2017 and 2018, was provided by COMMUNITY HEALTH FOUNDATION OF PUERTO RICO, INC.

(C) As per Report provided by COMMUNITY HEALTH FOUNDATION OF PUERTO RICO, INC.

*Certified to be a correct and true translation from the source text in Spanish to the target language English.*
*24/MAY/2022 - Andreea I. Boscor ATA-certified Spanish-English #525556*
*By Targem Translations Inc.*

1. To determine the PPS Rate:

   The total Costs from the 2017 and 2018 Financial Statements were taken, subtracting non-reimbursable expenses, and dividing by the average visits for years 2017 and 2018. The result was the PPS Rate for 2019. All the financial information used to determine the PPS rate, such as Financial Statements and visits, was provided by the Community Health Center.

2. El Reimbursement Manual [governing] Federally Qualified Health Centers (FQHC) sets forth as follows with regard to calculating the PPS Rate for a New FQHC (Page 13):

   *4.2.2.*
   *New FQHCs*
   *FQHCs receiving their initial designation after January 1, 2001, will be paid on an interim basis, an average visit rate of other FQHCs located in the same or adjacent area with similar caseloads until their permanent rates are determined. The new FQHC will receive this rate for the remainder of the calendar year in which it is established and will receive annual increases thereafter consistent with the PPS payment methodology.*
   *Within two (2) years of receiving its initial designation, the FQHC must demonstrate its actual costs using standard cost reporting methods, to establish its base visit rate.*

   Having financial information available from Center 330, we were able to determine the permanent PPS Rate of $43.69. Based on its location, this Center would be comparable to the Health Pro Med Center (Belaval), as both are located in the metropolitan area. The revised PPS Rate for 2017 for the Health Pro Med Center 330 is $146.72.

3. The periods that require calculating a wraparound, with an Interim PPS Rate, would be from August 1, 2017, to December 31, 2018. For the 2019 period, we were able to establish a PPS Rate applicable to Q3-2019 when the two years for the Interim PPS end.

4. CHF had a certification as a Look-Alike for the period from 08/01/2017 to 07/31/2020. As of September 3, 2019, they received a certification as a FQHC for the period from 09/01/2019 to 08/31/2021. I do not know how often this certification must be renewed. (If they have to renew it, it's already expired)

5. Community Health Foundation of Puerto Rico, Inc. Is filing a claim for collections since 2018.

TARGEM TRANSLATIONS

T 718.384.8040
W TargemTranslations.com
E projects@targemtranslations.com
A 185 Clymer St. Brooklyn, NY 11211

**TRANSLATOR'S CERTIFICATE OF TRANSLATION**

Translation from: Spanish (Puerto Rico) into English (US)

TARGEM Translations Inc.

I, Andreea I. Boscor, ATA-certified Spanish-English #525556, acting as translator at TARGEM Translations Inc., a NEW YORK City corporation, with its principal office at 185 Clymer Street, Brooklyn, NY, 11211, USA, certify that:

the English translated document is a true and accurate translation of the original Spanish and has been translated to the best of my knowledge.

Original Document Name: **Determinar el PPS Rate Community Heath Foundation DJ**

Signed this 24th of May 2022

American Translators Association
ata
Andreea Boscor
Spanish into English
Certification #525556
Certified Translator

Verify at www.atanet.org/verify

Andreea I. Boscor

# Exhibit F

## Schedule of FFS Payments

| | |
|---|---|
| Contractor: | FirstMedical Health Plan |
| Period Ending: | 12/31/2018 |

**Schedule 6.E (refer to tab 6.H for instructions)**

**Certification Statement of Fee-for-Service Payments During the Quarter for PR Health Insurance Administration (ASES)**

| PMG # | FED TAX ID | Name | Amount of FFS Payment for the month ending: (Specify the month below) | | | Total of Fee-for service payments during the quarter |
|---|---|---|---|---|---|---|
| | | | October | November | December | |
| 4309 | 660739219 | Community Health Foundation of Puerto Rico | 0 | 142467.65 | 154178.13 | $296,645.78 |
| | | | | | | $0.00 |
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I hereby attest that the information submitted in the accompanying files to this Certification is accurate and complete according to our records as of the date of this certification The accompanying files have detailed information that supports the numbers below for each of the following Primary Medical Groups

Name of Preparer Javier Andino

Title VP Administracion de Grupos

Signature Date

| | |
|---|---|
| Contractor: | FirstMedical Health Plan |
| Period Ending: | 3/31/2019 |

**Schedule 6.E (refer to tab 6.H for instructions)**

**Certification Statement of Fee-for-Service Payments During the Quarter for PR Health Insurance Administration (ASES)**

| PMG # | FED TAX ID | Name | Amount of FFS Payment for the month ending: (Specify the month below) | | | Total of Fee-for service payments during the quarter |
|---|---|---|---|---|---|---|
| | | | January | February | March | |
| 4309 | 660739219 | Community Health Foundation of Puerto Rico | 135,855.44 | 177,336.57 | 170,112.79 | $483,304.80 |
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Name of Preparer Javier Andino

Title VP Administracion de Grupos

Signature Date

| | |
|---|---|
| Contractor: | FirstMedical Health Plan |
| Period Ending: | 6/30/2019 |

**Schedule 6.E (refer to tab 6.H for instructions)**

**Certification Statement of Fee-for-Service Payments During the Quarter for PR Health Insurance Administration (ASES)**

| PMG # | FED TAX ID | Name | Amount of FFS Payment for the month ending: (Specify the month below) | | | Total of Fee-for service payments during the quarter |
|---|---|---|---|---|---|---|
| | | | April | May | June | |
| 4309 | 660739219 | Community Health Foundation of Puerto Rico | 169097.77 | 152537.05 | 139443.31 | $461,078.13 |
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Name of Preparer Javier Andino

Title VP Administracion de Grupos

Signature Date

| | |
|---|---|
| Contractor: | FirstMedical Health Plan |
| Period Ending: | 9/30/2019 |

**Schedule 6.E (refer to tab 6.H for instructions)**

**Certification Statement of Fee-for-Service Payments During the Quarter for PR Health Insurance Administration (ASES)**

| PMG # | FED TAX ID | Name | Amount of FFS Payment for the month ending: (Specify the month below) | | | Total of Fee-for service payments during the quarter |
|---|---|---|---|---|---|---|
| | | | July | August | September | |
| 4309 | 660739219 | Community Health Foundation of Puerto Rico | 182995.11 | 159375.09 | 166531.34 | $508,901.54 |
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Name of Preparer Javier Andino

Title VP Administracion de Grupos

Signature Date

| | |
|---|---|
| Contractor: | FirstMedical Health Plan |
| Period Ending: | 12/31/2019 |

**Schedule 6.E (refer to tab 6.H for instructions)**

**Certification Statement of Fee-for-Service Payments During the Quarter for PR Health Insurance Administration (ASES)**

| PMG # | FED TAX ID | Name | Amount of FFS Payment for the month ending: (Specify the month below) | | | Total of Fee-for service payments during the quarter |
|---|---|---|---|---|---|---|
| | | | October | November | December | |
| 4309 | 660739219 | Community Health Foundation of Puerto Rico | 157106.29 | 202618.68 | 140015.34 | $499,740.31 |
| | | | | | | $0.00 |
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| | |
|---|---|
| Name of Preparer | Javier Andino |
| Title | VP Administracion de Grupos |

Signature Date

| | |
|---|---|
| Contractor: | FirstMedical Health Plan |
| Period Ending: | 3/31/2020 |

**Schedule 6.E (refer to tab 6.H for instructions)**

**Certification Statement of Fee-for-Service Payments During the Quarter for PR Health Insurance Administration (ASES)**

| | PMG # | FED TAX ID | Name | Amount of FFS Payment for the month ending: (Specify the month below) | | | Total of Fee-for service payments during the quarter |
|---|---|---|---|---|---|---|---|
| | | | | January | February | March | |
| FM | 4309 | 660739219 | Community Health Foundation of Puerto Rico | $34,853.85 | $77,836.56 | $173,109.94 | $285,800.35 |
| MMM | 4309 | 660749601 | COMMUNITY HEALTH FOUNDATION OF PUERTO RICO INC. | $511,371.81 | $466,947.94 | $392,342.37 | $1,370,662.12 |

Period Ending: 6/30/2020

**Schedule 6.E (refer to tab 6.I for instructions)**

**Fee-for-Service Payments During the Quarter for PR Health Insurance Administration (ASES)**

| | PMG # | FED TAX ID | Name | Amount of FFS Payment for the month ending: (Specify the month below) | | | Total of Fee-for service payments during the prior quarter |
|---|---|---|---|---|---|---|---|
| | | | | April | May | June | |
| FM | 4309 | 660739219 | Community Health Foundation of Puerto Rico | $22,245.25 | $63,354.98 | $86,958.35 | $172,558.58 |
| MMM | 4309 | 660749601 | COMMUNITY HEALTH FOUNDATION OF PUERTO RICO INC. | $312,320.92 | $351,326.06 | $396,131.50 | $1,059,778.48 |

Period Ending: 09/30/2020

**Schedule 6.E (refer to tab 6.I for instructions)**

**Fee-for-Service Payments During the Quarter for PR Health Insurance Administration (ASES)**

| | PMG # | FED TAX ID | Name | Amount of FFS Payment for the month ending: (Specify the month below) | | | Total of Fee-for service payments during the prior quarter |
|---|---|---|---|---|---|---|---|
| | | | | JUL | AUG | SEP | |
| FM | 4309 | | Community Health Foundation of Puerto Rico | $57,433.91 | $47,456.34 | $37,409.20 | $6,482,186.57 |
| MMM | 4309 | 660749601 | COMMUNITY HEALTH FOUNDATION OF PUERTO RICO INC. | $50,103.55 | $53,403.84 | $59,394.35 | $162,901.74 |

Period Ending: 12/31/2020

**Schedule 6.E (refer to tab 6.I for instructions)**

**Fee-for-Service Payments During the Quarter for PR Health Insurance Administration (ASES)**

| | PMG # | FED TAX ID | Name | Amount of FFS Payment for the month ending: (Specify the month below) | | | Total of Fee-for service payments during the prior quarter |
|---|---|---|---|---|---|---|---|
| | | | | OCT | NOV | DEC | |
| FM | 4309 | 660739219 | Community Health Foundation of Puerto Rico | $10,684.31 | $11,164.83 | $14,451.91 | $999,959.80 |
| MMM | 4309 | 660749601 | COMMUNITY HEALTH FOUNDATION OF PUERTO RICO INC. | $53,589.52 | $55,933.13 | $57,804.47 | $596,270.03 |

**Contractor: 09 - First Medical MCO**
**Period Ending: 03/31/2021**

**Schedule 6.E (refer to tab 6.I for instructions)**
**Fee-for-Service Payments During the Quarter for PR Health Insurance Administration (ASES)**

| | PMG # | FED TAX ID | Name | Amount of FFS Payment for the month ending: (Specify the month below) | | | Total of Fee-for service payments during the prior quarter |
|---|---|---|---|---|---|---|---|
| FM | 4309 | 660739219 | Community Health Foundation of Puerto Rico | $9,673.48 | $16,352.88 | $14,116.66 | $40,143.02 |
| MMM | 4309 | 660749601 | COMMUNITY HEALTH FOUNDATION OF PUERTO RICO INC. | $54,920.55 | $62,303.47 | $71,800.78 | $189,024.8 |

**Contractor: 09 - First Medical MCO**
**Period Ending: 06/30/2021**

**Schedule 6.E (refer to tab 6.I for instructions)**
**Fee-for-Service Payments During the Quarter for PR Health Insurance Administration (ASES)**

| | PMG # | FED TAX ID | Name | Amount of FFS Payment for the month ending: (Specify the month below) | | | Total of Fee-for service payments during the |
|---|---|---|---|---|---|---|---|
| FM | 4309 | 660739219 | Community Health Foundation of Puerto Rico | $16,434.85 | $16,750.33 | $16,027.07 | $49,212.25 |
| MMM | 4309 | 660749601 | COMMUNITY HEALTH FOUNDATION OF PUERTO RICO INC. | $88,109.17 | $66,316.06 | $91,382.82 | $245,808.05 |